

# Exhibit 1



**Corporate Creations Network Inc.**  
801 US Highway 1 North Palm Beach, FL 33408

Massachusetts Mutual Life Insurance Company  
Jennifer Antaya Senior Paralegal  
MassMutual - Massachusetts Mutual Life Insurance Company  
1295 State Street  
Springfield MA 01111

November 14, 2024

## SERVICE OF PROCESS NOTICE

The following is a courtesy summary of the enclosed document(s). **ALL information should be verified by you.**

Item: 2024-383

Note: Any questions regarding the substance of the matter described below, including the status or how to respond, should be directed to the contact set forth in line 12 below or to the court or government agency where the matter is being heard. **IMPORTANT:** All changes or updates to the SOP contact individuals or their contact information must be submitted in writing to [SOPcontact@corpcreations.com](mailto:SOPcontact@corpcreations.com). Any changes will become effective upon written confirmation of Corporate Creations.

1.	<b>Entity Served:</b>	Massachusetts Mutual Life Insurance Company
2.	<b>Title of Action:</b>	Ricky D. Gordon vs. Massachusetts Mutual Life Insurance Company
3.	<b>Document(s) Served:</b>	Notice of Service of Process Summons Complaint Exhibits
4.	<b>Court/Agency:</b>	Broward County 17th Judicial Circuit Court
5.	<b>State Served:</b>	Florida
6.	<b>Case Number:</b>	CACE-24-011707
7.	<b>Case Type:</b>	Damages/Injuries
8.	<b>Method of Service:</b>	Email
9.	<b>Date Received:</b>	Thursday 11/14/2024
10.	<b>Date to Client:</b>	Thursday 11/14/2024
11.	<b># Days When Answer Due:</b> <b>Answer Due Date:</b>	20 Wednesday 12/04/2024 <span style="color: red;">CAUTION:</span> Client is solely responsible for verifying the accuracy of the estimated Answer Due Date. To avoid missing a crucial deadline, we recommend immediately confirming in writing with opposing counsel that the date of the service in their records matches the Date Received.
12.	<b>Sop Sender:</b> (Name, City, State, and Phone Number)	Martin J. Sperry Ft. Lauderdale, FL 954-727-0997
13.	<b>Shipped To Client By:</b>	Email Only with PDF Link
14.	<b>Tracking Number:</b>	
15.	<b>Handled By:</b>	101
16.	<b>Notes:</b>	Please note that this document was served upon the Department of Financial Services on 11/13/2024 and Corporate Creations received it on 11/14/2024.

**NOTE:** This notice and the information above is provided for general informational purposes only and should not be considered a legal opinion. The client and their legal counsel are solely responsible for reviewing the service of process and verifying the accuracy of all information. At Corporate Creations, we take pride in developing systems that effectively manage risk so our clients feel comfortable with the reliability of our service. We always deliver service of process so our clients avoid the risk of a default judgment. As registered agent, our role is to receive and forward service of process. To decrease risk for our clients, it is not our role to determine the merits of whether service of process is valid and effective. It is the role of legal counsel to assess whether service of process is invalid or defective. Registered agent services are provided by Corporate Creations Network Inc.



CHIEF FINANCIAL OFFICER  
JIMMY PATRONIS  
STATE OF FLORIDA

\*24-000364420\*

RICKY D. GORDON

CASE #: CACE-24-011707  
COURT: CIRCUIT  
COUNTY: BROWARD  
DFS-SOP #: 24-000364420

PLAINTIFF(S)

VS.

MASSACHUSETTS MUTUAL LIFE INSURANCE  
COMPANY

DEFENDANT(S)

\_\_\_\_\_  
SUMMONS, COMPLAINT, EXHIBIT, CCS, RFP

## **NOTICE OF SERVICE OF PROCESS**

NOTICE IS HEREBY GIVEN of acceptance of Service of Process by the Chief Financial Officer of the State of Florida. Said process was received in my office by ELECTRONIC DELIVERY on Wednesday, November 13, 2024 and a copy was forwarded by ELECTRONIC DELIVERY on Thursday, November 14, 2024 to the designated agent for the named entity as shown below.

MASSACHUSETTS MUTUAL LIFE INSURANCE COMPANY  
TRENT BAVARO, ATTN: CORPORATE CREATIONS NETWORK  
801 US HIGHWAY 1  
NORTH PALM BEACH, FL 33408

**\*Our office will only serve the initial process (Summons and Complaint) or Subpoena and is not responsible for transmittal of any subsequent filings, pleadings, or documents unless otherwise ordered by the Court pursuant to Florida Rules of Civil Procedure, Rule 1.080.**

A handwritten signature in black ink, appearing to read "Jimmy Patronis".

Jimmy Patronis  
Chief Financial Officer

DENNIS CAPLAN  
351 SW 136TH AVE STE 207  
DAVIE, FL 33325

TG1

Filing # 210555193 E-Filed 11/08/2024 09:54:04 AM

CACE-24-011707

IN THE COUNTY COURT OF THE 17<sup>th</sup> JUDICIAL CIRCUIT  
IN AND FOR BROWARD COUNTY, FLORIDA

CASE NO.: CACE-24-011707 Division. 18

RICKY D. GORDON,

Plaintiff,

vs.

MASSACHUSETTS MUTUAL LIFE  
INSURANCE COMPANY,

Defendant,

DATE \_\_\_\_\_ TIME \_\_\_\_\_

INITIAL \_\_\_\_\_ BADGE# \_\_\_\_\_

**SUMMONS**

THE STATE OF FLORIDA:

To All and Singular the Sheriffs of said State:

YOU ARE HEREBY COMMANDED to serve this Summons and a copy of the Complaint in this action on Defendant:

MASSACHUSETTS MUTUAL LIFE INSURANCE COMPANY

By serving Registered Agent:

CHIEF FINANCIAL OFFICER

200 E. GAINES STREET

TALLAHASSEE, FL 32399

Each Defendant is required to serve written defenses to the Complaint on Plaintiff's attorney to whose address is: Martin J. Sperry, Esq., Martin J. Sperry, P.A., 3860 W. Commercial Boulevard, Ft. Lauderdale, FL 33309, Telephone: (954) 727-0997, Fax: (954) 727-0998, [msperry@msperrylawfirm.com](mailto:msperry@msperrylawfirm.com), [ssklaw@aol.com](mailto:ssklaw@aol.com), [lcolman@msperrylawfirm.com](mailto:lcolman@msperrylawfirm.com) within 20 days after service of this summons on that Defendant, exclusive of the day of service, and to file the original of the defenses with the clerk of this court either before service on plaintiffs' attorneys or immediately thereafter. If a defendant fails to do so, a default will be entered against that defendant for the relief demanded in the complaint or petition.

NOV 13 2024

WITNESS my hand and seal of said Court on \_\_\_\_\_.

BRENDA D. FORMAN  
Clerk of Court

By \_\_\_\_\_  
Deputy Clerk



BRENDA D. FORMAN

This notice is provided pursuant to Administrative Order No. 2207-6/22.

**If you are a person with a disability who needs any accommodation in order to participate in this proceeding, you are entitled, at no cost to you, to the provision of certain assistance. Please contact ADA Coordinator, Room 20140, 201 S.E. Sixth Street, Fort Lauderdale, Florida 33301, 954-831-7721 at least 7 days before your scheduled court appearance, or immediately upon receiving this notification if the time before the scheduled appearance is less than 7 days; if you are hearing or voice impaired, call 711."**

“Si usted es una persona minusválida que necesita algún acomodamiento para poder participar en este procedimiento, usted tiene derecho, sin tener gastos propios, a que se le provea cierta ayuda. Tenga la amabilidad de ponerse en contacto con ADA Coordinator, Room 20140, 201 S.E. Sixth Street, Fort Lauderdale, Florida 33301, 954-831-7721, por lo menos 7 días antes de la cita fijada para su comparecencia en los tribunales, o inmediatamente después de recibir esta notificación si el tiempo antes de la comparecencia que se ha programado es menos de 7 días; si usted tiene discapacitación del oído o de la voz, llame al 711.”

“Si ou se yon moun ki enfim ki bezwen akomodasyon pou w ka patisipe nan pwo sedi sa, ou kalifye san ou pa gen okenn lajan pou w peye, gen pwovizyon pou jwen kèk èd. Tanpri kontakte ADA Coordinator, Room 20140, 201 S.E. Sixth Street, Fort Lauderdale, Florida 33301, 954-831-7721 nan 7 jou anvan dat ou gen randevou pou parèt nan tribunal la, oubyen imedyatman apre ou fin resevwa konvokasyon an si lè ou gen pou w parèt nan tribunal la mwens ke 7 jou; si ou gen pwoblèm pou

IN THE CIRCUIT COURT OF THE  
17TH JUDICIAL CIRCUIT, IN AND  
FOR BROWARD COUNTY, FLORIDA

CASE NO.:

RICKY D. GORDON,

Plaintiff,

vs.

MASSACHUSETTS MUTUAL LIFE  
INSURANCE COMPANY,

Defendant.

**COMPLAINT**

COMES NOW the Plaintiff, RICKY D. GORDON, by and through his undersigned attorneys, and sues the Defendant, MASSACHUSETTS MUTUAL LIFE INSURANCE COMPANY (MASSMUTUAL), and alleges as follows:

1. This is an action for damages in excess of \$50,000.00.
2. Plaintiff, RICKY D. GORDON, is a resident of Broward County, Florida and is otherwise sui juris.
3. Defendant, MASSMUTUAL is a foreign corporation authorized to and doing business in Broward County, Florida, including, but not limited to, selling and servicing disability insurance policies to individuals in the State of Florida and in this particular case had underwritten the applicable policies of insurance, both individual and Business Overhead Expense Policy Nos. 4744473, 4750574, 6014736, 4963278 and 6012560. The policies were issued by Connecticut Mutual Life Insurance Company

which merged with Massachusetts Mutual Life Insurance Company.

4. At all times material hereto there was in full force and effect the disability income and Business Overhead Expense policies issued by Defendant, MASSMUTUAL, to the Plaintiff which were binding contracts of insurance between the parties. The policies were initially issued on March 25, 1988, May 17, 1988, July 31, 1991, May 20, 1994 and October 2, 1999 under policy numbers 4744473, 4750574, 6014736, 4963278 and 6012560. Exhibits A, B, C, D, and E, respectively. The policies were reissued on October 29, 2018.

5. The purpose of the policies was to compensate the Plaintiff on a monthly basis should he suffer a total disability due to injuries or sickness. Within the policies, the term "disability" is, under the individual coverage:

**Total Disability.** You're totally disabled if because of sickness or injury you can't do the main duties of your occupation. You must be under a doctor's care.

**Partial (Residual) Disability.** You're partially (residually) disabled if because of sickness or injury:

- you can do some, but not all, of the main duties of your occupation.

OR

- you can work at your occupation no more than 3/4 of the hours you worked before becoming disabled.

In either case, you must be earning an income and have lost at least 1/4 of your predisability income for each month you make a claim for residual disability. Also, you must be under a doctor's care. If you are residually disabled you are also considered partially disabled.

Your residual disability may be extended even after you are back to work full time-time, if you continue to have an income loss. Through the sixth complete calendar month following your full recovery from a period of total and/or residual disability lasting one year or longer, you will continue to be considered residually disabled if you have lost at least 1/4 of your predisability income. During this period we will waive the requirement that:

- you can do some, but not all, of the main duties of your occupation
- OR
- you can work at your occupation no more than 3/4 of the hours you worked before becoming disabled.  
(emphasis added)

Under the Business Overhead Expense Policies' disability:

**Total Disability.** You are totally disabled if because of sickness or injury you can't do the main duties of your occupation. And you must be under a doctor's care.

You must be totally disabled for the full elimination period. We'll pay the first monthly benefit one month after the elimination period ends.

**Presumptive total disability.** If sickness or injury results in the total loss of sight, speech or hearing or the total loss of use of both hands, both feet, or one hand and one foot, it will be considered total disability while it continues. The requirement that you must be under a doctor's care will be waived.

**Partial disability.** You're partially disabled if because of sickness or injury:

- you can do some, but not all the duties of your occupation, or
- you can work at your occupation, no more than 3/4 the hours you worked before becoming disabled.

In either case, you must be under a doctor's care.  
(emphasis added)

6. Defendant, previously Connecticut Mutual, which was merged into Defendant in 1995, has conceded that if Plaintiff was practicing full time as a "trial attorney" at the time of his disability, then that is deemed his regular occupation. See attached Exhibit F.

7. The Plaintiff has provided Defendant with evidence of care by physicians and healthcare providers showing receipt of care by Plaintiff for the condition causing his disability, and that the disabling condition has caused him to be unable to perform his duties as a Litigation/Trial attorney.

8. On or about May 3, 2018, the Plaintiff filed a claim with the Defendant claiming disability due to anxiety, high blood pressure, panic attacks, excessive worry and energy, repetitive and speeded up thoughts, waking during the night, early morning awakening, overactivity, distractibility and more. The claim was approved for Residual Disability benefits under a reservation of rights until August 27, 2019, at which time, MASSMUTUAL not only wrongfully denied Plaintiff's claim of Total Disability, but terminated his Residual Disability benefits that it previously determined he was entitled to receive.

9. Medical records were submitted to Defendant which supported the fact that the Plaintiff was totally disabled as a trial lawyer, but Defendant denied that Plaintiff was totally disabled as a trial lawyer and then wrongfully terminated his residual benefits.

10. The Plaintiff has suffered and continues to suffer from a disability within the policies issued to him.

11. The Plaintiff has complied with all provisions of conditions precedent to filing suit. The Defendant, under the terms of its contract of insurance, is indebted to the Plaintiff for monthly payments, plus interest, commencing August 27, 2019 and going forward for the maximum benefit periods under the policies.

12. The Defendant has failed and refused to honor its obligations under the policies of insurance issued to the Plaintiff.

13. Defendant has breached the implied contractual covenant of good faith, fair dealings and commercial reasonableness.

14. Plaintiff has necessarily had to obtain the services of counsel and has agreed to pay a reasonable attorney's fee.

WHEREFORE, Plaintiff, RICKY D. GORDON, demands judgment against the defendant, MASSACHUSETTS MUTUAL LIFE INSURANCE COMPANY for all contract benefits, prejudgment interest, costs, interest and attorneys' fees and demands trial by jury of all rights triable by a jury.

Dated on 16<sup>th</sup> day of August, 2024.

By /s/ Martin J. Sperry  
MARTIN J. SPERRY  
Florida Bar No. 144917  
MARTIN J. SPERRY, P.A.  
3860 W. Commercial Boulevard  
Ft. Lauderdale, FL 33309  
(954) 727-0997 Telephone  
(954) 727-0998 Facsimile  
[msperry@mpsperrylawfirm.com](mailto:msperry@mpsperrylawfirm.com)  
[ssklaw@aol.com](mailto:ssklaw@aol.com)  
[lcolman@mpsperrylawfirm.com](mailto:lcolman@mpsperrylawfirm.com)

<b>Connecticut Mutual Life Insurance Company</b> Hartford, Connecticut • Since 1846	
Insured	Policy Number
<p>We at Connecticut Mutual Life believe you should read your policy. We've written it in plain English so you'll understand its terms. We will, subject to these terms, pay the benefits to you if you become disabled after the effective date. This policy is a legal contract between the Policyowner and the Insurer.</p> <p><b>READ YOUR POLICY CAREFULLY</b></p> <p><b>Benefits This Policy Provides</b></p> <ul style="list-style-type: none"> <li>• Income during total or residual disability.</li> <li>• Options to buy extra benefits.</li> <li>• Rehabilitation benefit.</li> <li>• Premium waived during disability.</li> <li>• Dividends.</li> <li>• Conditional right to continue the policy to age 75.</li> </ul> <p>Your policy is issued in consideration of your application and premium payments. A copy of your application is attached and made a part of this policy.</p> <p>We provide benefits for a loss arising from a sickness or disease that first appears (makes itself known) on or after the effective date and while this policy is in force. We also provide benefits for a loss resulting from an accidental bodily injury that happens on or after the effective date.</p> <p><b>Renewal Provision.</b> We won't cancel this policy. Nor will we increase the premiums from those shown on the Coverage Page. As long as you pay premiums on time, we'll continue coverage until the Anniversary on or following your 65th birthday.</p> <p>You have the conditional right to continue this policy to age 75. This is fully explained in the "Conditions For Continuing The Policy To Age 75" provision in Part 6—Other Benefits.</p> <p><b>Policy Index</b></p> <p>PART 1 Definitions        PART 2 Disability benefits        PART 3 Options to buy extra benefits        PART 4 Premiums        PART 5 Claims        PART 6 Other benefits        PART 7 When you're not covered        PART 8 General rules</p> <p><b>Ten Day Right To Examine Policy.</b> If for any reason you decide not to keep this policy, send it to us within 10 days after receiving it. Send it to our Home Office or to the agent who sold it to you. We'll treat the policy as though it never had been issued. We'll refund any premium paid.</p> <p>This policy is issued by Connecticut Mutual Life Insurance Company at our Home Office, 140 Garden Street, Hartford, Connecticut 06115 on the effective date.</p>	
<i>Bria Forman</i> Secretary	<i>My W. Ybarra</i> President
Counter by _____ _____ Licensed Resident Agent	
<p><b>DISABILITY INCOME POLICY</b>          (with Options to buy Additional Benefits)</p> <p>Noncancelable—Rates guaranteed          Guaranteed continuable to age 65          Conditionally continuable to age 75—          Subject to premium change          Participating in dividends</p>	

## COVERAGE PAGE

INSURED

RICKY D GORDON

4744473

POLICY NUMBER

## DISABILITY INCOME POLICY

DATE OF ISSUE MAR 25, 1988  
DATE OF REISSUE OCT 29, 2018

AGE 33

EFFECTIVE DATE	COVERAGE	MONTHLY BENEFIT	WAITING PERIOD	MAXIMUM* BENEFIT PERIOD	ANNUAL PREMIUM	PAYABLE TO YEAR
APR 15 1988	BASIC MONTHLY BENEFIT WITH ADJUSTABLE BENEFIT	\$4,300	90 DAYS TO 65	\$1,042.81	2019	
ADDITIONAL BENEFITS - SEE ATTACHED RIDERS FOR DETAILS-						
APR 15 1988	OWN OCCUPATION/ PRESUMPTIVE DIS RIDER	\$4,300		\$160.39	2019	
APR 15 1991	ADDITIONAL MONTHLY BENEFIT	\$3,650	90 DAYS TO 65	\$988.79	2019	
APR 15 1991	OWN OCCUPATION/ PRESUMPTIVE DIS RIDER	\$3,650		\$156.95	2019	
APR 15 1994	ADDITIONAL MONTHLY BENEFIT	\$2,100	90 DAYS TO 65	\$636.93	2019	
APR 15 1994	OWN OCCUPATION/ PRESUMPTIVE DIS RIDER	\$2,100		\$102.06	2019	
APR 15 1995	ADDITIONAL MONTHLY BENEFIT	\$950	90 DAYS TO 65	\$298.40	2019	
APR 15 1995	OWN OCCUPATION/ PRESUMPTIVE DIS RIDER	\$950		\$47.88	2019	
APR 15 1997	ADDITIONAL MONTHLY BENEFIT	\$1,850	90 DAYS TO 65	\$647.69	2019	
APR 15 1997	OWN OCCUPATION/ PRESUMPTIVE DIS RIDER	\$1,850		\$103.97	2019	

YOUR MAXIMUM MONTHLY BENEFIT IS \$12,850

TOTAL ANNUAL PREMIUM \$4,185.87

MONTHLY PREMIUM \$360.82

YOUR MAXIMUM ADDITIONAL ADJUSTABLE BENEFIT THAT MAY BE PURCHASED ON OR BEFORE APR 15 2010 IS \$7,505 SUBJECT TO THE COMPANY'S MAXIMUM PUBLISHED LIMITS AS DESCRIBED IN PART 3 OF THIS POLICY.

\*YOUR BENEFIT PERIOD FOR DISABILITY IS YOUR SPECIFIED BENEFIT PERIOD, BUT NOT BEYOND APR 15 2020. HOWEVER, THE BENEFIT PERIOD FOR YOUR MONTHLY BENEFIT WILL BE AT LEAST 24 MONTHS.

YOUR PREMIUM IS BASED ON NON-SMOKER RATES, DISCOUNTED BY 10% FROM THE SMOKER RATES.

NOT AN OFFICIAL COPY - CCIS - SUBSCRIBER - CCIS

**PART 1—****In PAR**

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**Income:** Gross earnings from any job or business and any amount you receive from Social Security, Workers' Compensation or State Cash Sickness Benefits. This doesn't include:

- Investment Income.
- Rent.
- Royalties.
- Any amount which is deductible from gross income as a business expense for income tax purposes.

**Unearned Income:** All Income which is not gross earnings from any job or business and not any amount you receive from Social Security, Workers' Compensation or State Cash Sickness Benefits. This may include but is not limited to:

- Investment Income.
- Rent.
- Royalties.

**Predisability Income:** Average monthly income for the last 12 months before the start of disability. Or the average for the last 24 months, if greater.

**Current Income:** Income for the month that a benefit is claimed.

**Loss Of Income:** Your predisability income minus your current income.

**Proof Of Insurability:** Proof you give us, or that we might obtain, that you're an acceptable risk.

**Assignment:** Legal transfer of one's interest to another party.

**Pre-existing Condition:** A pre-existing condition is a physical condition or sickness which during the 5 year period prior to the effective date of this policy, caused the insured to have received medical advice or treatment.

**Partial Disability:** You're partially disabled if because of sickness or injury:

- You can do some, but not all, of the main duties of your occupation.
- OR
- You can work at your occupation no more than  $\frac{3}{4}$  the hours you worked before becoming disabled.

In either case you must be under a doctor's care.

**PART 2—DISABILITY BENEFITS**

In PART 2, we discuss the different kinds of disability covered and the benefits provided for each. We'll pay only one benefit at a time.

Page 2

**The Kinds Of Disability Covered**

*1. Partial Disability*  
~~1. Partial Disability~~  
~~2. Total Disability~~  
~~3. Recurring Disability~~  
~~4. Loss of Income~~  
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payment will be carried forward to offset your benefits. This includes awards for past or future benefits or awards for partial or permanent disabilities. Disability benefits will be determined as if there was no lump sum benefits. Then that benefit, if any, will be subtracted each month from the lump sum until your lump sum is reduced to zero. You will not receive a benefit until the lump sum is reduced to zero.

(Example: You were disabled at age 45. Your current income is \$500 from Social Security. Your predisability income was \$3,000. Your loss of income is \$2,500 (\$3,000-\$500). The ratio of loss of income to pre-

disability income is  $\frac{\$2,500}{\$3,000}$  or 5/6. Your monthly

benefit payment will be 5/6ths of your basic monthly benefit.)

If the amount of monthly benefits you receive from Social Security, Workers' Compensation and State Cash Sickness Benefits increases during any one period of total disability, we won't include any increase above the amount you first received in current income.

**Residual Disability Benefit.** You must be residually disabled and have been totally and/or partially disabled for 12 months, or the full elimination period if longer. We'll pay the first monthly benefit one month later. Payments will continue for as long as you're residually disabled. But, we'll only pay up to the maximum benefit period. We won't pay beyond the Anniversary following your 65th birthday. The benefit is based on your loss of income as described in the "Total Disability Benefit" section. Except, your current will not include earnings from your job or business if those earnings are less than 25% of your predisability income.

(Example: You were disabled at age 35. Your current income is \$1,000 from your occupation. Your predisability income was \$3,000. Your loss of income is \$2,000 (\$3,000-\$1,000). The ratio of loss of income to

predisability income is  $\frac{\$2,000}{\$3,000}$  or 2/3. Your monthly

residual disability benefit payment will be 2/3rds of your basic monthly benefit.)

#### Special Disability Benefits

**Rehabilitation Program Benefit.** During any period in which you are receiving total or residual disability benefits, we'll also reimburse your expenses for taking part in a rehabilitation program we approve. We'll reimburse your expenses up to a maximum amount of 24 times your policy's maximum monthly benefit. This reimbursement will be in addition to your monthly disability benefit. We'll judge whether your continued participation would be worthwhile.

A rehabilitation program means:

- A recognized program operated by the Federal or State government.
- A formal program of rehabilitation at a licensed vocational school, business school or accredited college.
- Any other planned program.

Reimbursement for your expenses is subject to our approval. Expenses mean the cost of tuition, books and equipment that you actually pay for and that are required for the program.

**Adjustment To Predisability Income.** The amount of predisability income will be adjusted after 12 consecutive months of disability. For each benefit year afterward that predisability income is used to determine your monthly benefit, we'll increase the predisability income figure used for the preceding year. We'll increase it by the same percentage that the Consumer Price Index rose during the preceding calendar year, or the percentage that your income rose during the same period, whichever is less. Except that percentage will never be less than 5%. The CPI used will be the one used in adjusting Social Security Benefits. We'll ignore decreases in the CPI.

(Example: Ben's basic monthly benefit is \$2,200. He's been disabled for 12 consecutive months. His predisability income was \$4,000. Last year the CPI rose 6%. We now consider his predisability income to be \$4,240. His current income is \$1,500. His loss of income is \$2,740 (\$4,240 - \$1,500).

Ben's monthly benefit is  $\$2,200 \times \frac{\$2,740}{\$4,240}$  or \$1,422.

**Important:** We did not increase Ben's monthly benefit by 6%. We increased his predisability income figure by 6%. If Ben has no current income, the predisability income won't be used to determine benefits. In this case there will be no adjustment.)

By increasing the predisability income, you may qualify for a larger disability benefit (up to the amount of your basic monthly benefit). Once adjusted we will never let your predisability income decrease during that period of disability.

#### PART 3—OPTIONS TO BUY ADDITIONAL BENEFITS

In PART 3, we discuss how you can buy additional benefits without proof of good health.

**General.** During each option period, you may apply for additional basic monthly benefits to be effective on the Anniversary Date within the option period. You don't have to give us proof of good health. The Extended Term Benefits Rider and the Short Term Rider, if in force under your policy, will not apply to your additional benefits. If the Cost Of Living Rider and the Own Occupation/Presumptive Disability riders are in force under your policy they must apply to your additional benefits. They will be the same as under your policy.

**Option Periods.** Option periods run from 30 days before until 30 days after each Anniversary. Your last option period, however, ends 30 days after the Anniversary on or following your 55th birthday. If you're disabled during any option period, your right to buy additional benefits will be postponed until the option period following your recovery.

**Minimum Amounts You Can Buy.** In order to buy additional basic monthly benefits during any option period, you must qualify for at least \$100 on the basis of our published limits, your income, your unearned income and your other disability income benefits.

**Maximum Amount You Can Buy.** The maximum additional basic monthly benefits you can buy is the same as the basic monthly benefits you initially purchased. This maximum is subject to the following conditions:

- Before your 41st birthday, the additional benefit you buy during any option period cannot exceed this maximum.
- After your 41st birthday, the total additional benefit you may buy during any successive 3 option periods cannot exceed this maximum.
- This maximum amount may not exceed that permitted by our published limits. We may change these limits from time to time. If we do, you may go by either the limits in effect when you purchased your original coverage or by our new limits if higher. Your unearned income will be taken into consideration only if it exceeds the percentage published in our underwriting rules.
- The total additional basic monthly benefits that you purchase during all option periods cannot exceed the limits shown on the Coverage Page.
- If you purchased this policy before age 35, we will recalculate your maximum additional adjustable benefit as shown on your Coverage Page. We will recalculate this at the first option period on or after your 35th birthday that you apply for benefits. This recalculation could result in an increase. It can never result in a decrease.

The factors used to determine the maximum additional benefits you can buy are:

- Your average monthly income for the last 12 months, or the last 24 months, if greater.
- Your unearned income.
- Other disability income benefits.

**Required Number Of Purchases.** You must apply for and buy once in every three option periods, the maximum additional basic monthly benefit for which you qualify. If you qualify for less than \$100, your application will satisfy this requirement. If you don't meet this requirement, your right to buy additional benefits will end.

**How To Buy Additional Benefits.** Apply in writing on our form and pay the first additional premium to our Home Office or to an authorized agent. This must be done during an option period. You won't have to give us proof of good health. But you will have to give us up to date information on any other disability income benefits you bought or became entitled to since you last applied for additional benefits. You will also have to give us proof of your income and your unearned income.

If we approve your application, your additional benefits will go into effect on the Anniversary date within the option period. We'll give you an updated Coverage Page. It will show the benefit and premium amounts in effect when you buy the additional benefits.

**Benefit Restrictions.** Your additional benefits will be subject to the same restrictions or endorsements as your original benefits.

**Premiums For Additional Benefits.** The premium rates won't exceed those we applied to policies in your risk class on your policy's effective date. They'll be based on your age when you buy additional benefits.

**When Your Right To Buy Additional Benefits Ends.** Any of the following ends your right to buy additional benefits:

- 3 option periods pass without you applying for, and buying if we approve, maximum additional benefits.
- you request in writing that we end your right to buy.
- the 30th day after the Anniversary on or following your 55th birthday arrives.

**What Happens After You Can No Longer Buy Additional Benefits.** As long as your policy is still in effect, you'll have 31 days to do either of the following:

- **Continue Your Policy.** Your policy and all additional benefits will continue. Premiums won't be changed. If you later become disabled and receive Social Security, Workers' Compensation or State Cash Sickness Benefits, here's what we'll do to help you. We'll figure how much you would have received from these sources if you were disabled on the date your right to buy additional benefits under this policy ended. If that amount is less than what you actually receive, we'll only consider the lesser amount. This may provide you with a larger monthly disability benefit. We explain this in "Total disability benefit" in Part 2.
- **Exchange Your Policy.** You may exchange this policy for a different policy that does not include options to buy additional benefits. The basic monthly benefit of the new policy will be based on your income at the time you exchanged this policy. The elimination period and maximum benefit period will be the same as for the original basic monthly benefit on this policy. Any riders attached to this policy will be attached to the new policy. The premium rates will be those published for the new policy in your risk class on this policy's effective date.

If you're disabled or choose neither to exchange or continue your policy, we'll automatically continue it on a premium paying basis.

#### PART 4—PREMIUMS

*The annual premium is shown on the Coverage Page. In PART 4 we tell how, when and where to pay premiums.*

**Premium Payments.** Premiums are due in advance. The first is due on the effective date. Premiums after the first are due on the same day of the month as the effective date. Premiums may be paid annually. Or they may be paid more frequently as we allow. They must be paid to our Home Office or to one of our authorized agents.

**Grace Period.** Each premium after the first must be paid within 31 days after its due date. This 31 day period is called the "grace period." The policy will stay in effect during the grace period.

**Changing When You Pay.** You may request a change in the frequency of your payments on any Anniversary. This request must be in writing. Any change is subject to our approval.

**Refund After Death.** We'll refund any premium that was paid for coverage after the policy month in which you die. Our Home Office must first receive written notice of your death.

#### PART 5—CLAIMS

*There are certain things you must do when making a claim. In PART 5, we discuss these requirements. We also discuss payment of claims.*

##### How To Make A Claim

**Notice Of Disability.** Send a written notice of your disability to our Home Office or to one of our authorized agents. Send it within 20 days after the start of disability or as soon as reasonably possible. There's no required form.

**Claim Forms.** We'll then send you a claim form. If you don't receive one within 15 days after you sent notice, write us your own claim letter. Tell us what caused the disability. Describe your situation.

**Required Proof.** Whether on our claim form or your claim letter, send proof of your disability and any proof of reduced income that may be required. Send it to our Home Office as soon as possible. Required proof must also be received within 90 days of each monthly benefit payment claimed. If it's not possible to send it within 90 days, send it as soon as reasonably possible. Your claim won't be reduced because of the delay. But we won't accept proof of loss later than 1 year after it was due. We'll make an exception if you weren't then competent to make the claim.

We may require from time to time that you be examined by doctors we choose. We'll pay the cost. We may also require from time to time, satisfactory proof of your income before and during disability. This may include, but is not limited to, copies of your W-2 form and/or income tax returns.

##### Payment Of Claims

**When Benefits Are Paid.** We'll pay benefits monthly.

**When We'll Pay.** We'll pay benefits to you. If you're a minor or not competent to give a release, we may pay up to \$3,000 to any relative of yours who we believe is entitled.

If you die, we'll pay your estate all amounts due prior to your death. But we may pay up to \$3,000 to any relative of yours who we believe is entitled.

Any payment we make in good faith will fully discharge us for that payment.

**Part Payments.** Let us know as soon as you've recovered. If you recover during a month, we'll send you a pro-rata payment for the part of the month you were disabled.

#### PART 6—OTHER BENEFITS

*In PART 6, we discuss other benefits we provide.*

**Waiver Of Premiums.** We'll waive premiums that come due after you've been totally and/or partially disabled for 90 days from the same sickness or injury. You won't have to pay premiums that come due while you remain disabled. We won't waive premiums beyond the maximum benefit period. We'll refund any premium paid for a period up to 90 days before you qualify for this benefit.

We'll waive premiums for this policy and any attached riders. We'll waive premiums on the payment mode in effect when you become disabled.

**Dividends.** Each year we determine how much can be paid as dividends on our policies. We call this "the divisible surplus." Then we figure how much of the divisible surplus can be paid as a dividend on all policies like yours.

We'll pay any dividends on the Anniversaries. We don't expect that there will be any before the second Anniversary.

We pay dividends in cash. But if you ask, we'll apply them toward premiums. Or, we'll accumulate them for you. We'll accumulate dividends at an interest rate of not less than 3% a year. We won't credit interest for any part of a year.

**Payment Of Premiums By Accumulated Dividends.** If you request it in the application, or in writing while this policy is premium paying, we'll automatically use accumulated dividends, if sufficient, to pay any premium in default. This also applies to the premium for any benefit rider attached to this policy.

(Page 5, of 8)

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Page 7

**Reinstating The Policy.** The policy will end if premiums are not paid when due or within the grace period.

If we don't require an application and evidence of your good health, you may reinstate the policy (restore coverage) by paying the back premiums. Pay us or one of our authorized agents. The reinstatement date will be the date you pay the back premiums.

If we do require an application, you'll have to pay back premiums and provide evidence of your good health. Then the reinstatement date will be the date that we approve your application. If you aren't notified of either approval or disapproval, the policy will be reinstated 45 days after the date of your application.

The reinstated policy will cover injuries that occur after the reinstatement date. It will cover sickness that first appears (makes itself known) more than 10 days after the reinstatement date.

After reinstatement, the terms of the policy and attached riders will be the same as before termination. Except for terms added in connection with reinstatement.

**Conditions For Continuing The Policy To Age 75.** This policy ends on the Anniversary on or following your 65th birthday. But you may continue it each year until the Anniversary on or following your 75th birthday. This is provided you stay actively and gainfully employed full time, at least 30 hours a week.

You must tell us within 30 days before or after each Anniversary on or after your 65th birthday if you want to continue your policy. We may ask for proof that you're employed.

If this policy is continued past age 65 we will not allow an elimination period longer than 180 days. The maximum benefit period will be 24 months. We'll base the annual premium on your age and occupation then. Rates will be those we're using at the time.

If your active and gainful employment stops after we've continued your policy, coverage will end on the date you stop working. We'll refund any premiums paid for coverage after that date.

#### **PART 7—WHEN YOU'RE NOT COVERED**

*There are certain disabilities we don't cover. And there are times when we may suspend coverage. We discuss this in PART 7.*

**Disabilities Not Covered.** We don't cover disability caused or contributed to by:

- war (declared or not),
- normal pregnancy, except as described in the definition of "Sickness"
- normal childbirth, except as described in the definition of "Sickness"

**Suspended Coverage While In Military.** This policy will be suspended if and when you enter active military service. This applies to the military service of any country or international authority. This doesn't apply to active duty for training that lasts 90 days or less.

We'll refund that part of any premium paid for the suspended period.

If you're released from active duty within 5 years from the date you entered active military service, you may restore this policy. Make written application and pay the required premium within 90 days of your release from active duty. No proof of insurability is needed. Premiums will be at the same rates as if the policy hadn't been suspended.

The restored policy will cover only injuries that occur after the restoration date. Or sickness that first appears (makes itself known) more than 10 days after the restoration date.

The terms of the restored policy and riders will be the same as before suspension.

**Pre-existing Conditions Limitations.** A disability or loss caused by a pre-existing condition will be covered if the disability or loss commences 2 years after the effective date unless excluded by name or disease as provided in the contestable clause.

#### **PART 8—GENERAL RULES**

*PART 8 contains general rules that apply.*

**The Owner.** You (the Insured) are the owner of this policy.

**The Entire Contract.** The entire contract consists of: The policy. The application. Any attached riders, endorsements and other papers.

**Changes.** Any change must be approved by an officer of our company. You must sign any change that restricts your policy. The change must be attached to the policy. Our agents cannot make changes or waive any provision. We may charge for making a change.

**Assignments Or Transfers.** The benefits of this policy may be assigned. Any interest may be transferred. Our Home Office must receive written notice of the terms of the assignment or a copy of the assignment. If not, we won't take notice of the change. In any case, we won't be responsible for the validity of any assignment.

**Contesting Your Policy.** We may not contest this policy after it has been in force for 2 years during your lifetime. This excludes any period of disability related to a misrepresentation in your application. We won't use any misstatements in your application to deny a claim for benefits if your disability begins after a like 2 year period.

We won't deny a claim for disability which starts after 2 years from the date of issue because a disease or physical condition existed before coverage began; unless excluded from coverage by name or specific description.

We won't contest your policy or deny a claim for a disability caused by a disease or physical condition which you fully and accurately described in your application for coverage; unless the condition was excluded from coverage by name or specific description.

**Legal Actions.** No legal action may be brought to recover on this policy within 60 days after written proof of loss has been given as required by this policy. No action may be brought after the expiration of the applicable statute of limitations from the time of proof of loss is required to be given.

**Misstating Your Age Or Sex.** You may have misstated your age or sex in your application. If so, we'll change the benefit amounts. The change will be what your premiums would have bought if you had given your correct age or sex.

But we'll only be required to make a refund if at your correct age or sex we wouldn't have issued the policy at all. Or if at your correct age or sex, coverage would have ended before we accepted the premium. The refund will only cover premiums you paid for coverage you won't receive. We'll deduct any amounts we've paid you.

**State Laws.** Any provision that, on the effective date, conflicts with state laws where you reside, is changed to meet the minimum requirements of those laws.

P7-AB84(FL)

### OWN OCCUPATION/PRESUMPTIVE TOTAL DISABILITY RIDER

This rider modifies your policy and the Cost of Living Rider that may be in force. The modifications are described below. All definitions in your policy apply to this rider. Payment under this rider will also be in lieu of any other Total Disability Benefit payments under your policy.

#### Modifications To Part 2 Of Your Policy.

The following provision is added to Part 2—"Disability Benefits" of your policy.

**Presumptive Total Disability.** If sickness or injury results in the total loss of sight, speech or hearing or the total loss of use of both hands, both feet, or one hand and one foot, it will be considered total disability while it continues. The requirement that you must be under a doctor's care will be waived.

The third paragraph in the Total Disability Benefit provision (which is located in Part 2—Disability Benefits section of your policy) is deleted. The following is added:

Current income will include income from your occupation, as defined in Part 1 of your policy, and those amounts which you applied for and receive from Social Security, Workers' Compensation and/or State Cash Sickness benefits. Current income will not include earnings from any job or business other than your occupation. Also, current income will not include earnings from your occupation if those earnings are less than 25% of your pre-disability income. If you have no current income, your monthly benefit payment will equal your basic monthly benefit.

This definition of current income will apply to your policy and your Partial Disability Benefits Rider, if that rider is in force. The definition of current income included in your policy will apply to your other riders as if this rider were not in force.

#### Modifications To Rider.

Your policy may also have a Cost of Living Rider in force. If it does, your benefit for total disability will be the greater of the benefit provided under the Cost of Living Rider and this rider.

**Premiums.** This rider is made a part of your policy in consideration of your application and premium payments. A copy of your application is attached to and made a part of your policy. The annual premium and the effective date for this rider are shown on the Coverage Page of your policy. If

you applied for this rider after the policy's effective date, we'll send you a new Coverage Page. Premiums for this rider must be paid along with the premiums for your policy. If you keep your policy in effect after this rider ends, you'll no longer pay the premium for this rider.

**Dividends.** Each year we determine how much we can pay as dividends. We discuss how dividends are paid in the "Other Benefits" section of your policy. We use the same procedure to figure the dividends we'll pay on all riders like yours.

**Contesting Your Rider.** We may not contest this rider after it has been in force for two years during your lifetime. This excludes any period of disability related to a misrepresentation in your application. We won't use any misstatements in your application to deny a claim for benefits if your disability begins after a like a 2 year period.

We won't deny a claim for disability which starts after 2 years from the date of issue because a disease or physical condition existed before coverage began; unless excluded from coverage by name or specific description.

We won't contest your rider or deny a claim for a disability caused by a disease or physical condition which you fully and accurately described in your application for coverage; unless the condition was excluded from coverage by name or specific description.

**Misstating Your Age Or Sex.** You may have misstated your age or sex in your application. If so, we'll change the amount which we would otherwise pay under this rider. The change will be what your premiums would have been if you had given your correct age or sex.

**Termination.** This rider will end on the earliest of the following dates:

- 31 days after the due date of any unpaid premium.
- as of the next premium due date upon your written request.
- the Anniversary on or after your 65th birthday.
- the date that your policy ends.

CONNECTICUT MUTUAL LIFE INSURANCE COMPANY

*Ria Flemagem*

Secretary

ENDORSEMENT

CHANGE OF INSURER NAME AND ADDRESS  
NOTICE OF ANNUAL MEETING

CONNECTICUT MUTUAL LIFE INSURANCE COMPANY ("Connecticut Mutual") and MASSACHUSETTS MUTUAL LIFE INSURANCE COMPANY ("MassMutual") have merged. MassMutual is the surviving company. As a result, MassMutual has succeeded to all liabilities, duties and rights of Connecticut Mutual. All references in this policy/contract to Connecticut Mutual are hereby changed to MassMutual.

The MassMutual Home Office is:

Massachusetts Mutual Life Insurance Company  
Springfield, Massachusetts 01111-0001  
1-800-272-2216

The back page of this policy/contract is hereby changed to add the following Notice of Annual Meeting:

The Insured/Annuitant is hereby notified that by virtue of this policy/contract he or she is a member of Massachusetts Mutual Life Insurance Company and is entitled to vote either in person or by proxy at any and all meetings of said Company. The annual meetings are held at its Home Office, in Springfield, Massachusetts on the second Wednesday of April in each year at 2 o'clock p.m.

The Endorsement forms a part of, and should be attached to, this policy/contract.

MASSACHUSETTS MUTUAL LIFE INSURANCE COMPANY

*Pia Flanagan*

Secretary

## ENDORSEMENT

The contract modifications outlined below are applicable to your existing Disability Income Policy.

## Part 1:

The definition of *Partial Disability* is modified to read:

You're partially disabled if because of sickness or injury:

- You can do some, but not all of the main duties of your occupation.

OR

- You can work at your occupation no more than 4/5 the hours you worked before becoming disabled.

In either case you must be under a doctor's care.

## Part 2:

The following is added to the *Kinds of Disability Covered* provision:

**Presumptive Total Disability.** If sickness or injury results in the total loss of sight, speech or hearing or the total loss of use of both hands, both feet, or one hand and one foot, it will be considered total disability while it continues. The requirement that you must be under a doctor's care will be waived.

The definition of *Residual Disability* is modified to read:

You're residually disabled if because of sickness or injury:

- You can do some, but not all, of the main duties of your occupation.

OR

- You can work at your occupation no more than 4/5 of the hours you worked before becoming disabled.

In either case, you must be earning an income and have lost at least 1/5 of your predisability income for each month you make a claim for residual disability. Also, you must be under a doctor's care. If you are residually disabled you are also considered partially disabled.

Your residual disability benefit may be extended even after you are back to work full-time, if you continue to have an income loss. Through the sixth complete calendar month following your full recovery from a period of total and/or residual disability lasting one year or longer, you will continue to be considered residually disabled if you have lost at least 1/5 of your predisability income. During this period we will waive the requirements that:

- You can do some, but not all, of the main duties of your occupation.

OR

- You can work at your occupation no more than 4/5 the hours you worked before becoming disabled.

The *Adjustment to Predisability Income* provision is modified to read as follows:

The amount of predisability income will be adjusted after 12 consecutive months of disability. For each benefit year afterward, we'll increase the predisability income figure used for the preceding year. We'll increase it by the same percentage that the Consumer Price Index rose during the preceding calendar year, or the percentage that your income rose during the same period, whichever is less. Except that the percentage will never be less than 5%. The CPI used will be the one used in adjusting Social Security Benefits. We'll ignore decreases in the CPI.

*(Example: Ben's basic monthly benefit is \$2,200. He's been disabled for 12 consecutive months. His predisability income was \$4,000. Last year the CPI rose 6%. We now consider his predisability income to be \$4,240. His current income is \$1,500. His loss of income is \$2,740 (\$4,240 - \$1,500).)*

*Ben's monthly benefit is \$2,200 ×  $\frac{\$2,740}{\$4,240}$  or \$1,422.*

*Important: We did not increase Ben's monthly benefit by 6%. We increased his predisability income figure by 6%. If Ben has no current income, the predisability income will be increased so that should he have current income in a given year, these adjustments will qualify Ben for a larger disability benefit.)*

By increasing the predisability income, you may qualify for a larger disability benefit (up to the amount of your basic monthly benefit). Once adjusted we will never let your predisability income decrease during that period of disability.

This endorsement is a part of the policy to which it is attached. Issued by CONNECTICUT MUTUAL LIFE INSURANCE COMPANY, Hartford, Connecticut.

*Pia Flanagan*  
Secretary

(Page 1 of 2)

ENDORSEMENT

The definition of Predisability Income in the DEFINITIONS section is modified to read as follows:

Average monthly income for the last 12 or 24 months before the start of disability or the highest consecutive 24 months during the 60 months prior to disability, whichever is greater.

This endorsement is a part of the policy to which it is attached. Issued by CONNECTICUT MUTUAL LIFE INSURANCE COMPANY, Hartford, Connecticut.

*Pia Flanagan*  
Secretary

(Page 1 of 2)

**ENDORSEMENT**

**CONNECTICUT MUTUAL LIFE INSURANCE COMPANY**

**ConnMuMatic**

**PREMIUM PAYMENT SERVICE**

For the purpose of collecting premiums under this policy we will be authorized to withdraw funds from your account. If we accept this authorization premiums will be paid on a monthly basis.

Premiums will be computed at a percentage of the annual premium. The percentage is shown below. They will be payable on the first day of each policy year and every month thereafter.

If this authorization is no longer in effect, premiums will be payable monthly to the next quarterly increment. They will be payable quarterly thereafter. You may elect to pay premiums annually or semi-annually as provided in the Policy.

All terms of the Policy will apply to premiums on a monthly basis.

The word "Policy" as used in this form also means "Contract".

Issued by Connecticut Mutual Life Insurance Company, 140 Garden Street, Hartford, Connecticut.

**CONNECTICUT MUTUAL LIFE INSURANCE COMPANY**

*Pia Flanagan*

Secretary

Percentage of Premium	Applies To
8.54%	Policies below #3,288,000
8.62%	Policies above #3,288,000
8.70%	86 Series



## Duplicate of Lost Policy

INSURED	POLICY NUMBER(S)
RICKY D GORDON	4744473

This policy is a duplicate of the original policy which has the same number and was prepared according to our current records. We issued this duplicate because we were furnished with evidence that the original policy was lost or destroyed.

If the original policy is ever found, it must be returned to us for cancellation.

This duplicate policy is issued under the terms of the Lost Policy Agreement filed with us at our Home Office.

10/31/2018

MASSACHUSETTS MUTUAL LIFE INSURANCE COMPANY

*Pia Flemagom*  
Secretary

Massachusetts Mutual Life Insurance Company (MassMutual), 1295 State Street, Springfield, MA 01111-0011 and its subsidiaries, C.M. Life Insurance Company and MML Bay State Life Insurance Company, 100 Bright Meadow Boulevard, Enfield, Connecticut 06082-1981.



Agency No. Application For Additional  
Disability Income Benefits

Connecticut Mutual Life Insurance Company, Hartford, Connecticut

IDENTIFICATION	1. A. The Name of the Insured is: <b>R I C K Y D O G O N D O N</b>							
	B. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	C. You were born on: <b>(mo, day, yr)</b>		D. Your birth state is: <b>N.Y.</b>	E. Your residence state is: <b>Florida</b>	F. Your business state is: <b>Florida</b>		
	G. Policy Number(s) affected by this application: <b>4344, 473</b>					H. Your Social Security number is: <span style="background-color: black; color: black;">XXXXXXXXXX</span>		

Complete Questions #2-10 for both an option under an adjustable benefit contract or an option under an additional benefits rider.

INSURABILITY	2. The Amount of the Additional Benefit is: <b>\$1,850.00</b>					6. Are you currently disabled? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	3. In what state are you employed? <b>Florida</b>					7. A. Will your employer continue salary or other payments if you are disabled? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	4. Existing Total Disability, Accident and Health Insurance					B. If yes, how much per month? <b>\$.....</b>			
	Source or Company	Monthly Income Sickness	Income Accident	Benefit Period Accident	Sickness	Year Issued	C. How long? <b>..... months.</b>		
	Conn. Mutual	11,000	11,000	65	65	1988	8. A. Your annual earned income after business expenses but before taxes <b>\$463,834</b>		
	Total	11,000	11,000				B. All other annual income <b>\$3,167</b>		
5. Is the employer paying the premium under a qualified plan? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					9. The Amount of the Prepayment is: (must be prepaid) <b>\$.....64.79</b>				
					10. Have you smoked cigarettes within the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No				

Complete Questions #11-15 only for an option under an additional benefits rider.

POLICY INFORMATION	11. <input checked="" type="checkbox"/> Regular Option				
	<input type="checkbox"/> Alternate Option for marriage, or after birth or adoption of a child:				
	I was married to _____ on _____ (Name of spouse) _____ (Date) _____				
I am the parent of _____ as of _____ (Name of child) _____ (Birth or adoption date) _____					
12. Premiums are payable: <input type="checkbox"/> A <input type="checkbox"/> SA <input type="checkbox"/> Q <input checked="" type="checkbox"/> MCS <input type="checkbox"/> Allot			14. Dividends: <input type="checkbox"/> Applied <input checked="" type="checkbox"/> Cash <input type="checkbox"/> Accumulate		
13. APD <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			15. Do you have dependent children? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		

COMMENTS	16. <span style="font-size: 2em; color: gray; opacity: 0.5;">NOT APPLICABLE</span>				

This Application is made in accordance with and subject to the provisions of the insurability agreement contained in the above policy. No agent may change the terms of this application or any coverage issued by the Company. And no agent may waive any of the Company's rights or requirements. If the date of issue of the coverage applied for is within two years of the Date of Issue of the Adjustable Benefit contract, or the additional benefits rider, the undersigned represent(s) that the statements and answers pertaining to the insurability of the proposed insured in the Application for that policy or rider were as of its date true and complete to the best knowledge and belief of the undersigned. The original Application shall form a part of this Application. This is agreed by the undersigned. Receipt of a Notice of Insurance Information Practices is hereby acknowledged.

Signed at ..... *Conn. J. Arnold Jr.* ..... on ..... *3-11-1982* .....Witnessed by ..... *P. J. ...* ..... Signature of  
Soliciting Agent ..... *P. J. ...* ..... Proposed InsuredSignature of  
Proposed Insured .....  
Signature of Owner of  
Original Policy if other  
than Proposed Insured .....

Agency No. 218		Application For Additional Disability Income Benefits									
Connecticut Mutual Life Insurance Company, Hartford, Connecticut											
IDENTIFICATION	1. A. The Name of the Insured is: (first, middle, last)		R I C K Y D.		G O R D O N						
	B. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		C. You were born on: (mo, day, yr)		D. Your birth state is: new York		E. Your residence state is: Florida		F. Your business state is: Florida		
	G. Policy Number(s) affected by this application: 4744473										
	H. Your Social Security number is:										
Complete Questions #2-10 for both an option under an adjustable benefit contract or an option under an additional benefits rider.											
INSURABILITY	2. The Amount of the Additional Benefit is: \$...9.50 <sup>00</sup>					6. Are you currently disabled? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
	3. In what state are you employed? Florida					7. A. Will your employer continue salary or other payments if you are disabled? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
	4. Existing Total Disability, Accident and Health Insurance					B. If yes, how much per month? \$.....					
	Source or Company	Monthly Income Sickness	Income Accident	Benefit Period Accident	Period Sickness	Year Issued	C. How long? ..... months.				
	Conn. Mutual	10,050	10,050	65	65	85	8. A. Your annual earned income after business expenses but before taxes \$...365,750				
	Total	10,050	10,050				B. All other annual income \$.....				
5. Is the employer paying the premium under a qualified plan? <input type="checkbox"/> Yes <input type="checkbox"/> No					9. The Amount of the Prepayment is: (must be prepaid) \$...297.31 <sup>41</sup>						
10. Have you smoked cigarettes within the last 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
Complete Questions #11-15 only for an option under an additional benefits rider.											
POLICY INFORMATION	11. <input checked="" type="checkbox"/> Regular Option <input type="checkbox"/> Alternate Option for marriage, or after birth or adoption of a child: I was married to _____ on _____ (Name of spouse) _____ (Date) _____										
	I am the parent of _____ as of _____ (Name of child) _____ (Birth or adoption date) _____										
	12. Premiums are payable: <input type="checkbox"/> A <input type="checkbox"/> SA <input type="checkbox"/> Q <input checked="" type="checkbox"/> MCS <input type="checkbox"/> Allot					14. Dividends: <input type="checkbox"/> Applied <input checked="" type="checkbox"/> Cash <input type="checkbox"/> Accumulate					
	13. APD <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					15. Do you have dependent children? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
16. _____											
<p>This Application is made in accordance with and subject to the provisions of the insurability agreement contained in the above policy. No agent may change the terms of this application or any coverage issued by the Company. And no agent may waive any of the Company's rights or requirements. If the date of issue of the coverage applied for is within two years of the Date of Issue of the Adjustable Benefit contract, or the additional benefits rider, the undersigned represent(s) that the statements and answers pertaining to the insurability of the proposed insured in the Application for that policy or rider were as of its date true and complete to the best knowledge and belief of the undersigned. The original Application shall form a part of this Application. This is acknowledged by the undersigned. Receipt of a Notice of Insurance Information Practices is hereby acknowledged.</p>											
Signed at ..... on ..... 5-12-1991											
Witnessed by Soliciting Agent ..... <i>B. L.</i>											
Signature of Proposed Insured <i>RL</i>											
Signature of Owner of Original Policy if other than Proposed Insured <i>RL</i>											

This Application is made in accordance with and subject to the provisions of the insurability agreement contained in the above policy. No agent may change the terms of this application or any coverage issued by the Company. And no agent may waive any of the Company's rights or requirements. If the date of issue of the coverage applied for is within two years of the Date of Issue of the Adjustable Benefit contract, or the additional benefits rider, the undersigned represent(s) that the statements and answers pertaining to the insurability of the proposed Insured in the Application for that policy or rider were as of its date true and complete to the best knowledge and belief of the undersigned. The original Application shall form a part of this Application. This is acknowledged by the undersigned. Receipt of a Notice of Insurance Information Practices is hereby acknowledged.

Signed at 524A 3rd Avenue, Ft. on 9-12-1951

Witnessed by By L Signature of Proposed Insured N  
Soliciting Agent

Signature of  
Proposed Insured *N.L.*  
Signature of Owner of  
Original Policy if other  
than Proposed Insured

Agency No.  
008Application For Additional  
Disability Income Benefits

Connecticut Mutual Life Insurance Company, Hartford, Connecticut

RECEIVED  
MAR 28 1994  
NEW BUSINESS

IDENTIFICATION	1. A. The Name of the Insured is: (first, middle, last)		R I C K Y D G O R D O N								
	B. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	C. You were born on: (mo, day, yr)		D. Your birth state is: NEW YORK		E. Your residence state is: FLORIDA		F. Your business state is: Florida			
	G. Policy Number(s) affected by this application:		4,944,473					H. Your Social Security number is: [REDACTED]			

Complete Questions #2-10 for both an option under an adjustable benefit contract or an option under an additional benefits rider.

INSURABILITY	2. The Amount of the Additional Benefit is: \$ 2,100.....					6. Are you currently disabled? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	3. In what state are you employed? FLORIDA					7. A. Will your employer continue salary or other payments if you are disabled? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	4. Existing Total Disability, Accident and Health Insurance					B. If yes, how much per month? \$.....							
	Source or Company	Monthly Income Sickness	Accident	Benefit Period Accident	Sickness	Year Issued	C. How long? ..... months.						
	Conn. Mutual	7950	7950	65	65	1988	8. A. Your annual earned income after business expenses but before taxes \$ 239,000....						
	Total	7950	7950				B. All other annual income \$.....						
5. Is the employer paying the premium under a qualified plan? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No													
9. The Amount of the Prepayment is: (must be prepaid) \$ ..... 63.70													
10. Have you smoked cigarettes within the last 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No													

Complete Questions #11-15 only for an option under an additional benefits rider.

POLICY INFORMATION	11. <input checked="" type="checkbox"/> Regular Option <input type="checkbox"/> Alternate Option for marriage, or after birth or adoption of a child: I was married to _____ on _____ (Name of spouse) (Date)										
	I am the parent of _____ as of _____ (Name of child) (Birth or adoption date)										
	12. Premiums are payable: <input type="checkbox"/> A <input type="checkbox"/> SA <input type="checkbox"/> O <input checked="" type="checkbox"/> MCS <input type="checkbox"/> Allot					14. Dividends: <input type="checkbox"/> Applied <input checked="" type="checkbox"/> Cash <input type="checkbox"/> Accumulate					
	13. APD <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					15. Do you have dependent children? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					

COMMENTS	16. _____										

This Application is made in accordance with and subject to the provisions of the insurability agreement contained in the above policy. No agent may change the terms of this application or any coverage issued by the Company. And no agent may waive any of the Company's rights or requirements. If the date of issue of the coverage applied for is within two years of the Date of Issue of the Adjustable Benefit contract, or the additional benefits rider, the undersigned represent(s) that the statements and answers pertaining to the insurability of the proposed insured in the Application for that policy or rider were as of its date true and complete to the best knowledge and belief of the undersigned. The original Application shall form a part of this Application. This is agreed by the undersigned. Receipt of a Notice of Insurance Information Practices is hereby acknowledged.

Signed at ORLANDO, FLORIDA on 3-7-1994

Witnessed by  
Soliciting Agent *[Signature]*Signature of  
Proposed Insured *[Signature]*  
Signature of Owner of  
Original Policy if other  
than Proposed Insured *[Signature]*

RECEIVED

MAY 24 1994

NEW BUSINESS

## AMENDMENT TO PENDING APPLICATION

To: Connecticut Mutual Companies, 140 Garden St., Hartford, Connecticut

FILE WITH APPN M.S. 281

Proposed Insured: RICKY D. GORDON

Policy Number: 4744473  
No.

Agency: 008

Part 2 Dated:

The following changes and additional statements as indicated below are made with respect to application for insurance described below.

## Adjustable Benefit (AB):

With	Without	Amount	Waiting Period-Days	Benefit Period-Duration
		Adjustable Basic Monthly Benefit to: \$		
		Adjustable Additional Monthly Benefit to: \$		

## With    Without    Rider:

		Lifetime Total Disability	\$
		COLA Rider Max %	\$
		Partial Disability	\$
		Social Security Supplement	\$
		Extended Benefit	\$
		Extended Term	\$
		Short Term A	\$
		Short Term B	\$
		Future Insurability Option	\$
		Future Insurability Option II	\$
		Own Occupation	\$

||| The request for non-smoker rate is hereby withdrawn.

||| I am not currently disabled.

||| Coverage with will be permanently discontinued effective within 60 days from the issue date of this policy.

||| An additional policy of monthly benefit to be issued on the same terms and conditions to include the same provisions as specified in the prior application.

||| Application is hereby made for an extra premium class disability income policy to be issued with a monthly income and premium schedule as specified in the prior application.

||| Riders issued under this policy shall also carry an extra premium class rating.

I verify that my 1993 K1 income was at least \$9,000.

Except as changed above, my answers and statements to application Parts One and Two are true and complete. They are true and complete to the best of my knowledge and belief as if made at the time I sign this amendment. A copy of my application is attached. Other than to comply with the Company's underwriting requirements, I have not sought or received medical advice or treatment since the date of the Part Two.

It is agreed by the undersigned that these changes and statements shall be incorporated in the application referred to above as fully and completely as if they had been originally set forth therein, and shall be subject in all respects to the agreements contained in the application.

Signed at \_\_\_\_\_

CORAL JEWEL, Florida

on

5-19-94

Date

City and State

Please  
Sign X

Applicant - if other than proposed insured

Proposed Insured  
RICKY D. GORDON

## WORKSHEET II FOR DISABILITY INCOME

## C6. PREMIUM BILLING: (Select one)

## DIRECT BILLING

Annual

Semi-Annual

Quarterly

 Monthly Check Service

## FRANCHISE BILLING

New Franchise Number

(Submit billing form F874 for new franchise)

Add to Existing Franchise

# \_\_\_\_\_  
(Number)

## C7. IS PROPOSED INSURED ELIGIBLE FOR:

A. Social Security  Yes  No  
 B. Worker's Compensation  Yes  No  
 C. State Cash Sickness Benefit  Yes  No

## C8. AUTOMATIC PREMIUM DIVIDEND:

 Yes  No

## C9. ANY DEPENDENT CHILDREN:

 Yes  No

## C10. DIVIDENDS: (Select one)

Accumulations  
Applied  
 Cash

## C11. PREMIUM TO BE PAID BY:

Employer  Insured

## C12. WILL EMPLOYER CONTINUE YOUR SALARY OR INCOME

IF DISABLED:  Yes  NoIf Yes, 3 Amount for 3 Month(s)

C13. EARNED INCOME	Amount	C14. UNEARNED INCOME	Amount
a. Salary, Fees, Commissions & Bonus	<u>75,000</u>	Dividends and Interest	
b. Pension and Profit Sharing Contributions	<u>—</u>	Net Capital Gains	
c. Earnings from Other Occupations (describe)	<u>—</u>	Rental Income (after expenses, before depreciation)	
d. Total Earnings (a + b + c)	<u>75,000</u>	Other (describe)	
e. Deductible Business Expenses		Total Unearned Income	<u>—</u>
f. Total Net Earned Income (d - e)	<u>75,000</u>		

C15. TOTAL NET WORTH IF ONE MILLION DOLLARS OR MORE: (assets minus liabilities) \$ 10

## C16. ANY EXISTING COVERAGE TO BE DISCONTINUED UPON THIS ISSUE?

IF YES: Company    Yes  NoAmount Per Month   Date Discontinued   

## C17. DISABILITY INCOME IN FORCE: (Include name of group carrier)

COMPANY	YEAR ISSUED	MONTHLY AMOUNT	BENEFIT PERIOD	WAIT	EMPLOYER PAY?	
					YES	NO
<u>None</u>						

Additional information, include details of "Yes" answers:

C13(e) INCLUDED, A PER BUSINESS EXPENSE

169760

## NONMEDICAL

*(Consult Underwriting Guide to New Business E707)*

D1. NAME AND ADDRESS OF PERSONAL PHYSICIAN (IF NONE, SO STATE):

**D2. INSURED HEIGHT/WEIGHT:**

Name:

\_\_\_\_ ft. \_\_\_\_ in. \_\_\_\_ lbs.

D3. DATE AND REASON LAST CONSULTED:

**D4. DIAGNOSIS AND TREATMENT (INCLUDE TYPE OF TREATMENT, MEDICATIONS, LENGTH OF HOSPITAL STAY)**

D5. A. HAVE YOU EVER BEEN TREATED FOR OR HAD ANY KNOWN INDICATION OF: (If yes, circle specific condition(s) and give details below) Yes  No

B. HAVE YOU EVER BEEN TREATED FOR OR HAD ANY KNOWN INDICATION OF ANY DISORDER OF:  
*(If yes, circle specific condition(s) and give details below)*

Chest Pain	Pneumonia	Immune Disorder
High Blood Pressure	Emphysema	Hepatitis
Heart Attack	Arthritis	Intestinal Disorders
Stroke	Lymph Node Disorder	Venereal Disease
Diabetes	Seizure	Depression
Tumor	Paralysis	Emotional Disorders
Cancer	Blood Disorder	Physical Impairment

details below)		Yes	No
Skin	Joints	Blood Vessels	
Neck	Eyes	Liver	
Back	Ears	Kidney	
Spine	Heart	Urinary Tract	
Bones	Lungs		

D6. Other than above, within the past 5 years have you had any illness, infection, injury or surgery, physical examination, electrocardiogram, X-Ray or laboratory study, or been a patient in a hospital or other medical facility?

Yes | No

D7. Have you smoked cigarettes at any time in the past 12 months?

DB. Have you ever requested or received a pension, benefits or payment because of injury, sickness or disability?

D9. Have you ever used cocaine or been advised to restrict the use of alcohol or drugs?

D10. DETAILS: *Include diagnoses, dates, duration, names and addresses of all attending physicians and medical facilities.*

## CONNECTICUT MUTUAL COMPANIES, HARTFORD, CONNECTICUT 06154

Connecticut Mutual Life Insurance Company  
C.M. Life Insurance Company (a stock life insurance company)

— Issuing company shown in Part I —

AGENCY NUMBER \_\_\_\_\_

## PART II OF APPLICATION

Proposed  
InsuredRICKY  
Archibald Gordon

Birth Date: \_\_\_\_\_

Answer unless exam being made:

Height 6 ft. 4 in. Weight 170 lbs.

## 1. a. Name and address of your personal physician (if none, so state):

Name: Dr. ...

Number/Street: ...

City/State/Zip Code: ...

## b. Date and reason last consulted? ...

## c. What diagnosis was made and what treatment prescribed? (include type of treatment, medications, length of hospital stay) ...

## 2. Have you ever been treated for or had any known indication of:

- a. Disorder of eyes, ears, nose or throat?
- b. Dizziness, fainting, headache, seizures or convulsions, paralysis or stroke?
- c. Depression, mental or nervous disorder or attempted suicide?
- d. Infection, shortness of breath, persistent hoarseness or cough, blood spitting, bronchitis, pleurisy, asthma, emphysema, tuberculosis or chronic respiratory disorder?
- e. Chest discomfort or pain, palpitation, high blood pressure, rheumatic fever, heart murmur, heart attack or other disorder of the heart or blood vessels?
- f. Jaundice, intestinal bleeding, ulcer, hernia, colitis, diverticulitis, hemorrhoids, recurrent indigestion, pancreatitis or other disorder of the stomach, intestines, liver or gall bladder?
- g. Sugar, albumin, blood or pus in urine, stone or other disorder of kidney, bladder, prostate or reproductive organs?
- h. Diabetes, thyroid or other endocrine disorders?
- i. Neuritis, sciatica, rheumatism, arthritis, gout or disorder of the muscles or bones, including the spine, back or joints?
- j. Deformity, lameness or amputation?
- k. Disorder of skin, breasts, lymph glands, cyst, tumor or cancer?
- l. Allergies, immune disorder, venereal disease, anemia or other disorder of the blood?
- m. Alcoholism or drug use?
- 3. Are you now under observation or taking treatment?
- 4. Have you had any change in weight in the past year?
- 5. Have you smoked cigarettes at any time within the past 12 months?
- 6. Other than above, have you within the past 5 years:
  - a. Had any mental or physical disorder, illness, injury or surgery?
  - b. Had a checkup or consultation or been a patient in a hospital, institution, clinic, sanatorium or other medical facility?
  - c. Had electrocardiogram, X-ray or other diagnostic test?
  - d. Been advised to have any diagnostic test, hospitalization or surgery which was not completed?
- 7. Have you ever requested or received a pension, benefits or payment, because of an injury, sickness or disability?
- 8. Is there a family history (parents, brothers, sisters) of:
  - a. Diabetes, kidney disease, cancer, mental illness or suicide?
  - b. Heart disease, heart attack or angina, high blood pressure, stroke or any other disorder of the heart or blood vessels known before age 60?

I have read all statements and answers in this application (consisting of Parts One and Two and any amendments thereto) and represent that they are true and complete to the best of my knowledge and belief, and agree that they shall be the basis of and a part of the consideration for the insurance applied for.

Signed at: ...

City and State

Signature of Proposed

Insured or Parent if

Proposed Insured a Minor

on: 2-22-85

Date

Witness: ...

D. J. Rosenthal, M.D.

F11-86

(Signature of Examiner or Licensed Agent) HARRINGBOROWICH, M.D.

(Page 7 of 8)

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**DISABILITY INCOME POLICY  
(with Options to buy Additional Benefits)**

Noncancelable—Rates guaranteed  
Guaranteed continuable to age 65  
Conditionally continuable to age 75—  
Subject to premium change  
Participating in dividends

RECEIVED

APR 04 1991

NEW BUSINESS

Agency No.

008

Application For Additional  
Disability Income Benefits

Connecticut Mutual Life Insurance Company, Hartford, Connecticut

IDENTIFICATION	1. A. The Name of the Insured is: <b>RICKY D. GORDON</b>		E.S.Q.			
	B. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	C. You were born on: <b>(mo, day, yr)</b>		D. Your birth state is: <b>NEW YORK</b>	E. Your residence state is: <b>FLORIDA</b>	F. Your business state is: <b>FLORIDA</b>
	G. Policy Number(s) affected by this application: <b>4,744,473</b>					
	H. Your Social Security number is: <b>██████████</b>					

Complete Questions #2—10 for both an option under an adjustable benefit contract or an option under an additional benefits rider.

INSURABILITY	2. The Amount of the Additional Benefit is: <b>\$...4,150</b>				6. Are you currently disabled? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	3. In what state are you employed? <b>Florida</b>				7. A. Will your employer continue salary or other payments if you are disabled? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	4. Existing Total Disability, Accident and Health Insurance				B. If yes, how much per month? <b>\$.....</b>	
	Source or Company	Monthly Income Sickness	Benefit Period Accident	Period Sickness	Year Issued	C. How long? <b>..... months.</b>
	Conn. Mutual	4300	4300	4300	4300	88
	Total	4300	4300			
5. Is the employer paying the premium under a qualified plan? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
8. A. Your annual earned income after business expenses but before taxes <b>\$...185,000</b>						
B. All other annual income <b>\$...11,414</b>						
9. The Amount of the Prepayment is: (must be prepaid) <b>\$...11,299</b>						
10. Have you smoked cigarettes within the last 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						

Complete Questions #11—15 only for an option under an additional benefits rider.

POLICY INFORMATION	11. <input checked="" type="checkbox"/> Regular Option		
	<input type="checkbox"/> Alternate Option for marriage, or after birth or adoption of a child:		
	I was married to _____	on _____	(Name of spouse)
I am the parent of _____	as of _____	(Name of child)	
12. Premiums are payable: <input type="checkbox"/> A <input type="checkbox"/> SA <input type="checkbox"/> Q <input checked="" type="checkbox"/> MCS <input type="checkbox"/> Allot		14. Dividends: <input type="checkbox"/> Applied <input checked="" type="checkbox"/> Cash <input type="checkbox"/> Accumulate	
13. APD <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		15. Do you have dependent children? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	

COMMENTS	16. <b>NOTICE</b>
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This Application is made in accordance with and subject to the provisions of the insurability agreement contained in the above policy. No agent may change the terms of this application or any coverage issued by the Company. And no agent may waive any of the Company's rights or requirements. If the date of issue of the coverage applied for is within two years of the Date of Issue of the Adjustable Benefit contract, or the additional benefits rider, the undersigned represent(s) that the statements and answers pertaining to the insurability of the proposed insured in the Application for that policy or rider were as of its date true and complete to the best knowledge and belief of the undersigned. The original Application shall form a part of this Application. This is agreed by the undersigned. Receipt of a Notice of Insurance Information Practices is hereby acknowledged.

Signed at ..... **CORA L. SMITH, Jr.** ..... on ..... **3-30-1991** .....Witnessed by  
Soliciting Agent ..... **Ag. L.** .....

Signature of  
Proposed Insured **X**  
Signature of Owner of  
Original Policy if other  
than Proposed Insured .....

169760

Connecticut Mutual Life Insurance Company  
 CM Life Insurance Company

PART I

## COMBINATION LIFE AND DISABILITY APPLICATION

Life  
 Disability

AGENCY NUMBER 208

COMPLETE FOR ALL CASES

A1. PROPOSED INSURED:

(first, middle, last)

RICKY D GORDON

A2. SEX:

Female

Male 

A3. Date of Birth:

Month Day Year

A4. Birth State:

NY

A5. INSURED'S SOCIAL SECURITY NO.

(Select one)

TAX ID NO.

A6.  OWNER'S SOCIAL SECURITY NO.

A7. POLICYOWNER NAME: (If other than insured)

(first, middle, last)

A8. INSURED'S EMPLOYER NAME:

RICKY D GORDON PA

A9. (If less than 2 years with current employer)

INSURED'S FORMER EMPLOYER NAME:

A10. ADDRESS:

INSURED'S RESIDENCE	NUMBER/STREET:	760 N.W. 48 AVE NYE		
	CITY/STATE/ZIP CODE:	COCONUT CREEK		FLORIDA 33063
INSURED'S FORMER RESIDENCE	(If less than 2 years of current residence)			
	NUMBER/STREET:			
	CITY/STATE/ZIP CODE:			
INSURED'S EMPLOYER'S ADDRESS	NUMBER/STREET:	RICKY D. GORDON, PA		
	CITY/STATE/ZIP CODE:	2842-A UNIVERSITY DRIVE		
		CORAL SPRINGS		FLORIDA 33065
INSURED'S FORMER EMPLOYER	(If less than 2 years with current employer)			
	NUMBER/STREET:			
	CITY/STATE/ZIP CODE:			
POLICYOWNER If Other Than Insured	NUMBER/STREET:			
	CITY/STATE/ZIP CODE:			

## A11. PREMIUM NOTICES TO:

## A. LIFE INSURANCE:

Proposed Insured:  
Policyowner:Residence  
ResidenceEmployer  
OtherOther (If other, indicate name  
and address below)

Name:

Number/Street:

City/State/Zip Code:

## B. DISABILITY INCOME: Proposed Insured:

Residence

Employer

Other (If other, indicate name  
and address below)Name: RICKY D. GORDON, USANumber/Street: P.O. BOX 63-6410

City/State/Zip Code:

MARLAPPEFLORIDA33863A12. INSURED'S OCCUPATION TITLE: ATTORNEYDUTIES: TRIAL PRACTICEA13. How long employed in current job? Years 2 Months 0A14. Have you been actively at work daily on a full-time basis for the past 3 months? If no, explain.  
(Disregard vacation days, normal non-working days and absences that total less than 7 days.) Yes  NoA15. Select One:  Smoker Rate  Non-smoker Rate  Juvenile (0-15) Rate

## COMPLETE FOR ALL INSURANCE: Write additional instructions and details of yes answers in space provided below.

	Yes	No		Yes	No
A16. Do you plan to change your occupation?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	A24a. In the past three years have you been in a motor vehicle accident, or charged with a "moving" violation of any motor vehicle law or has your driver's license ever been suspended?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
A17. Do you plan any foreign residence or travel? If yes, submit "supplement" (F257).	<input checked="" type="checkbox"/>	<input type="checkbox"/>	b. State	Operator's license number:	
A18. In the past three years have you taken part in any avocation such as motor vehicle racing, parachute jumping, hang gliding, skin or scuba diving? Is such activity planned? If yes, submit Avocation Supplement. (F1093)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	FL	<input type="text"/>	
A19. Within the past 3 years, have you flown as a pilot or crew member? If yes, submit Aviation Supplement. (F1093)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Details here:	<input type="text"/>	
A20. Do you plan to replace or change any life, or disability in- come now in force on your life? If yes, submit required documents.	<input checked="" type="checkbox"/>	<input type="checkbox"/>			
A21. Do you plan to pay for this policy by a policy loan on an existing policy?	<input checked="" type="checkbox"/>	<input type="checkbox"/>			
A22. Has any insurance contract on your life terminated in the last six months?	<input checked="" type="checkbox"/>	<input type="checkbox"/>			
A23. Is any application for life, disability, accident or health insurance pending or is the reinstatement of any policy pending?	<input checked="" type="checkbox"/>	<input type="checkbox"/>			

## A25. PROPOSED INSURED'S PHONE NUMBER FOR PERSONAL HISTORY INTERVIEW CALL:

Home : (            )            -           Preferred Time:                    A.M.                    P.M.Business: (305) 421-3205 Ext.           Preferred Time:            A.M.            P.M.462-7005

## A26. ADDITIONAL INSTRUCTIONS FOR PHI CALL:

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169760

## WORKSHEET I FOR DISABILITY INCOME

C1.  ADJUSTABLE BENEFIT (AB)Step Premium:  YES  NO

AMOUNT	WAIT	BENEFIT PERIOD
\$ 4300	090	65

RIDERS	<input checked="" type="checkbox"/> PARTIAL	SHORT TERM A	SHORT TERM B	EXTENDED TERM
AMOUNT				
WAIT	090			
BENEFIT PERIOD				

Lifetime Accident and Sickness

 Cost of Living 5 % Own OccupationC2.  LEVEL BENEFIT (NC)Step Premium:  YES  NO

AMOUNT	WAIT	BENEFIT PERIOD
\$ _____	_____	_____

RIDERS	<input checked="" type="checkbox"/> PARTIAL	SOCIAL SECURITY	SHORT TERM A	SHORT TERM B	EXTENDED TERM
AMOUNT					
WAIT					
BENEFIT PERIOD					

Lifetime Accident and Sickness

Cost of Living \_\_\_\_\_ %

Own Occupation

Future Insurability Option 1 \$ \_\_\_\_\_

Future Insurability Option 2 \$ \_\_\_\_\_

## C3. GUARANTEED CONTINUABLE (GC)

	SECTION 1A	SECTION 1B	SECTION 2
AMOUNT			
WAIT			
BENEFIT PERIOD			

## RIDERS:

Extended Benefit

(Select one)

1 Year 4 Year

Cost of Living \_\_\_\_\_ %

Future Insurability Option 1 \$ \_\_\_\_\_

## C4. BUSINESS OVERHEAD EXPENSE (BOE)

AMOUNT	2,500
WAIT	60
BENEFIT PERIOD	18 MONTHS

## RIDERS:

 FUTURE INSURABILITY OPTION 2 \$ 500.00

## C5. Complete the following for Business Overhead Expense Plan: List the current average monthly expenses. In the event of joint occupancy or joint ownership; list only the expenses for which the proposed insured is liable.

Rent	\$ 125.00	Telephone	\$ 400.00
Mortgage Interest Payment	\$ 0	Employees' Salaries	\$ 0
Utilities (gas; light; water)	\$ 100.00	Accountant Fees	\$ 0
Taxes on real property	\$ 0	Depreciation	\$ 417.00
Cost of leasing equipment	\$ 0	Maintenance	\$ 83.00
Malpractice, property and liability insurance	\$ 215.00	service	\$ 0
Dues for professional societies	\$ 60.00	Other	\$ 0
Business subscriptions	\$ 150.00		

TOTAL MONTHLY EXPENSES: \$ 2720.00

**Connecticut Mutual Life Insurance Company**  
Hartford, Connecticut • Since 1846

Insured

Policy Number

We at Connecticut Mutual Life believe you should read your policy. We've written it in plain English so you'll understand its terms. We will, subject to these terms, pay the benefits to you if you become disabled after the effective date.

**Benefits this policy provides**

- Business overhead expense payments during total disability
- Income during partial disability
- Premium waived during disability
- Dividends
- Conditional right to continue the policy to age 75

Your policy is issued in consideration of your application and premium payments. A copy of your application is attached and made a part of this policy.

We provide benefits for a loss arising from a sickness or disease that first appears (makes itself known) on or after the effective date and while this policy is in force. We also provide benefits for a loss resulting from an accidental bodily injury that happens on or after the effective date.

We won't cancel this policy. Nor will we increase the premiums. As long as you pay premiums on time, we'll continue coverage until the Anniversary on or following your 65th birthday.

**Policy Index**

- PART 1 Definitions
- PART 2 Disability benefits
- PART 3 Premiums
- PART 4 Claims
- PART 5 Other benefits
- PART 6 When you're not covered
- PART 7 General rules

**Ten day right to examine.** If for any reason you decide not to keep this policy, send it to us within 10 days after receiving it. Send it to our Home Office or to the agent who sold it to you. We'll treat the policy as though it never had been issued. We'll refund any premium paid.

This policy is issued by Connecticut Mutual Life Insurance Company at our Home Office, 140 Garden Street, Hartford, Connecticut 06154 on the effective date.

*Pia Flanagan*

Secretary

*My W. Moore*

President

Registrar

Countersigned  
by \_\_\_\_\_ Licensed Resident Agent

**EXHIBIT B****BUSINESS OVERHEAD EXPENSE POLICY**

Noncancelable—Rates guaranteed

Guaranteed continuable to age 65

Conditionally continuable to age 75

Subject to premium change

Participating in dividends

**CONNECTICUT  
MUTUAL**  
A Family of Blue Chip Companies

## COVERAGE PAGE

INSURED RICKY D GORDON

4750574 POLICY NUMBER

## DISABILITY INCOME POLICY

DATE OF ISSUE MAY 17, 1988 AGE 33

EFFECTIVE DATE	COVERAGE	MONTHLY BENEFIT	WAITING PERIOD	MAXIMUM* BENEFIT PERIOD	ANNUAL PREMIUM	PAYABLE TO YEAR
MAY 17 1988	MONTHLY OVERHEAD EXPENSE BENEFIT	\$2,500	90 DAYS	1 YEAR	\$137.50	2019

YOUR MAXIMUM MONTHLY BENEFIT IS \$2,500	TOTAL ANNUAL PREMIUM	\$137.50
	MONTHLY PREMIUM	\$11.85

IT IS ANTICIPATED THAT DIVIDENDS WILL BE PAYABLE AFTER 2 YEARS AND MAY BE USED AS DESCRIBED IN YOUR POLICY.

YOUR PREMIUM IS BASED ON SMOKER RATES, DISCOUNTED BY 10% FROM THE SMOKER RATES.

**PART 1—DEFINITIONS**

*In PART 1, we define several terms used in this policy.*

**Effective date:** The date that the policy is "in effect." Coverage starts on that date. An Anniversary falls each year on the same month and day as the effective date.

**Elimination period:** The number of days immediately following the start of your disability. No benefits are provided during the elimination period. Your elimination period is shown on the Coverage Page.

**Maximum benefit period:** The maximum length of time we'll pay benefits.

**Sickness:** A sickness or disease that first appears (makes itself known) on or after the effective date. It includes disability from the transplant of a part of your body to the body of another and complications of pregnancy. After you have been totally disabled for 90 days, normal pregnancy and normal childbirth, for a pregnancy having its inception on or after the effective date, will be considered a sickness.

**Injury:** An accidental bodily injury that happens on or after the effective date.

**Occupation:** Your regular occupation at the start of disability.

**Doctor:** A licensed medical practitioner other than the insured.

**Income:** Gross earnings from any job or business. This doesn't include:

- Investment income.
- Rent.
- Royalties.
- Any amount which is deductible from gross income as a business expense for income tax purposes.

**Unearned Income:** All income which is not gross earnings from any job or business. This may include, but is not limited to:

- Investment income.
- Rent.
- Royalties.

**Proof of insurability:** Proof you give us, or that we might obtain, that you're an acceptable risk.

**Assignment:** Legal transfer of one's interest to another party.

**Pre-existing Condition:** A pre-existing condition is a physical condition or sickness which during the 5 year period prior to the effective date of this policy, caused the insured to have received medical advice or treatment.

**Overhead expenses:** Expenses you normally have in running your office or business. These expenses include, but are not limited to:

Rent	Electricity
Heat and water	Telephone
Interest payments on the business premises you own and use in running your business	Cost of leasing equipment
Employees' salaries (except as limited below)	Laundry
	Depreciation

Overhead expenses do not include:

Salaries, fees, drawing accounts or other compensation received by any family member, colleague or partner working for or with you.

Cost of goods for sale

Additions to inventory

Cost of tools, instruments or wares used in your profession or occupation.

Any kind of expense which you didn't have in running your office or business immediately before becoming totally disabled.

Mortgage principal payments.

If overhead expenses are shared with one or more persons, we only cover your portion of the expenses.

**PART 2—DISABILITY BENEFITS**

*In PART 2, we discuss the different kinds of disability covered and the benefits we provide.*

**The kinds of disability covered**

**Total disability:** You're totally disabled if because of sickness or injury you can't do the main duties of your occupation. And you must be under a doctor's care.

You must be totally disabled for the full elimination period. We'll pay the first monthly benefit one month after the elimination period ends.

**Presumptive total disability:** If sickness or injury results in the total loss of sight, speech or hearing or the total loss of use of both hands, both feet, or one hand and one foot, it will be considered total disability while it continues. The requirement that you must be under a doctor's care will be waived.

**Partial disability:** You're partially disabled if because of sickness or injury:

- you can do some, but not all the duties of your occupation, or
- you can work at your occupation no more than 3/4 the hours you worked before becoming disabled

In either case, you must be under a doctor's care.

**Recurring disability:** This is a related disability that starts less than 6 months after a period of total or partial disability. We will treat the recurring disability as a continuation of the prior one. If the elimination period has already been satisfied, no new elimination period is required. If the elimination period has not been satisfied, periods of recurring disability may be accumulated to satisfy the elimination period.

*(Example: Bob's policy has a one-month elimination period for total disability. He has a stomach ulcer attack and is totally disabled for more than one month. Two months after returning to work, Bob has a second stomach ulcer attack and is totally disabled again for 2 months. The second attack is treated as a continuation of the first. So, Bob will start to receive total benefits without another elimination period.)*

**The benefits provided for disability**

**Total disability benefit—business overhead expense benefit.** Each monthly benefit we pay will either be equal to your share of the actual business overhead expenses, or be in the amount shown on the Coverage Page, whichever is less.

You will get benefits for as long as you are totally disabled, up to the maximum benefit period. If your actual expenses are less than the amount shown on the Coverage Page, we will extend benefits beyond the maximum benefit period. We will pay until the total benefit paid equals your monthly overhead expense benefit times your maximum benefit period. In no event, will we pay beyond the sixth month after the end of your maximum benefit period.

*(Example: Your monthly overhead expense benefit is \$1,000. Your maximum benefit period is 12 months. Your actual overhead expenses during 12 months came to \$10,000 and this is what we paid to the end of the maximum benefit period. We'll extend benefits until we pay another \$2,000 (\$12,000 – \$10,000). But we won't pay beyond the sixth month after the end of your maximum benefit period.)*

You won't get a larger benefit if you're disabled due to more than one cause.

**Partial disability benefit—business overhead expense benefit.** Benefits will start after the elimination period shown on the Coverage Page. We'll pay the first monthly benefit 1 month after the elimination period ends. We'll pay benefits up to the 12th month following the start of your disability.

The amount of your partial disability benefit will be 1/2 the total disability benefit.

We'll pay the partial disability benefit if you meet all the following conditions:

- You're totally and/or partially disabled for the elimination period shown on the Coverage Page
- Your total disability benefits, if they were payable, have ended
- You're partially disabled but not totally disabled.

**PART 3—PREMIUMS**

*The annual premium is shown on the Coverage Page. In PART 3 we tell how, when and where to pay premiums.*

**Premium payments.** Premiums are due in advance. The first is due on the effective date. Premiums after the first are due on the same day of the month as the effective date. Premiums may be paid annually. Or they may be paid more frequently as we allow. They must be paid to our Home Office or to one of our authorized agents.

**Grace period.** Each premium after the first must be paid within 31 days after its due date. This 31 day period is called the "grace period." The policy will stay in effect during the grace period.

**Changing when you pay.** You may request a change in the frequency of your payments on any Anniversary. This request must be in writing. Any change is subject to our approval.

**Refund after death.** We'll refund any premium that was paid for coverage after the policy month in which you die. Our Home Office must first receive written notice of your death.

**PART 4—CLAIMS**

*There are certain things you must do when making a claim. In PART 4, we discuss these requirements. We also discuss payment of claims.*

**How to make a claim**

**Notice of disability.** Send a written notice of your disability to our Home Office or to one of our authorized agents. Send it within 20 days after the start of disability, or as soon as reasonably possible. There's no required form.

**Claim forms.** We'll then send you a claim form. If you don't receive one within 15 days after you sent notice, write us your own claim letter. Tell us what caused the disability. Describe your situation.

**Required proof.** Whether on our claim form or your claim

letter, send proof of your disability and any proof of monthly overhead expenses that may be required. Send it to our Home Office as soon as possible. Required proof must also be received within 90 days of each monthly benefit payment claimed. If it's not possible to send it within 90 days, send it as soon as reasonably possible. Your claim won't be reduced because of the delay. But we won't accept proof of loss later than 1 year after it was due. We'll make an exception if you weren't then competent to make the claim.

We may require from time to time that you be examined by doctors we choose. We'll pay the cost. We may also require from time to time, satisfactory proof of your expenses before and during disability.

**Payment of claims**

**When benefits are paid.** We'll pay benefits monthly.

**Whom we'll pay.** We'll pay benefits to you. If you're a minor or not competent to give a release, we may pay up to \$3,000 to any relative of yours who we believe is entitled.

If you die, we'll pay your estate all amounts due prior to your death. But we may pay up to \$3,000 to any relative of yours who we believe is entitled.

Any payment we make in good faith will fully discharge us for that payment.

**Part payments.** Let us know as soon as you've recovered. If you recover during a month, we'll send you a pro-rata payment for the part of the month you were disabled.

**PART 5—OTHER BENEFITS**

*In PART 5, we discuss other benefits we provide.*

**Waiver of premiums.** We'll waive all premiums that come due after you've been totally and/or partially disabled for 90 days from the same sickness or injury. You won't have to pay premiums that come due while you remain disabled. We won't waive premiums beyond the maximum benefit period. We'll refund any premium paid for a period up to 90 days before you qualify for this benefit.

We'll waive premiums for this policy and any attached riders.

We'll waive premiums on the payment mode in effect when you become disabled.

**Exchange Privilege.** If, prior to attained age 60, you wish to apply to exchange this policy for one that provides benefits unrelated to business overhead expenses, you may make the exchange without producing additional evidence of good health or the nature of your occupation. The statements you made in your application for this policy will also apply to the new policy. You will have to prove that you are employed. You must not be totally or partially disabled.

The right to exchange your policy will be subject to the company's published limits of maximum monthly benefit based on your income, unearned income and other disability income coverage you may own. We may change these limits from time to time. If we do, you may elect to use the limits in effect when you purchased your original coverage or our new limits if higher. Your unearned income will be taken into consideration only if it exceeds the percentage published in our underwriting rules.

Subject to our published limits, the monthly benefit and elimination period under the new policy will be the same as the monthly benefit and elimination period on the Coverage Page of this policy. The new policy will be issued on the policy form the company then uses to provide total and partial disability benefits unrelated to business overhead expenses to new policyholders in the occupation described in the application for this policy. The maximum benefit period for the new policy will be two years. The cost of your new policy will be based on the rates new policyholders pay at the age when you apply for the exchange. The new policy may contain the same exclusions for diseases or physical conditions that this policy contained, if appropriate. Conversion will be made effective on the date of the application. Any unearned premium under this policy will be returned.

Upon exchange, we'll measure the time period stated in the "Contesting your policy" provision of any new policy from the issue date of that policy. If this policy can't be contested,

we can only use misstatements in the application for the new policy to contest that policy.

**Dividends.** Each year we determine how much can be paid as dividends on our policies. We call this "the divisible surplus". Then we figure how much of the divisible surplus can be paid as a dividend on all policies like yours.

We'll pay any dividends on the Anniversaries. We don't expect that there will be any before the second Anniversary.

We pay dividends in cash. But if you ask, we'll apply them toward premiums. Or, we'll accumulate them for you. We'll accumulate dividends at an interest rate of not less than 3% a year. We don't credit interest for any part of a year.

**Payment of premiums by accumulated dividends.** If you request it in the application, or in writing while this policy is premium paying, we'll automatically use accumulated dividends, if sufficient, to pay any premium in default. This also applies to the premium for any benefit rider attached to this policy.

**Reinstating the policy.** The policy will end if premiums are not paid when due or within the grace period.

If we don't require an application and evidence of your good health, you may reinstate the policy (restore coverage) by paying the back premiums. Pay us or one of our authorized agents. The reinstatement date will be the date you pay the back premiums.

If we do require an application, you'll have to pay back premiums and provide evidence of your good health. Then the reinstatement date will be the date that we approve your application. If you aren't notified of either approval or disapproval, the policy will be reinstated 45 days after the date of your application.

The reinstated policy will cover injuries that occur after the reinstatement date. It will cover sickness that first appears (makes itself known) more than 10 days after the reinstatement date.

After reinstatement, the terms of the policy and attached riders will be the same as before termination. Except for terms added in connection with reinstatement.

**Conditions for continuing the policy to age 75.** This policy ends on the Anniversary on or following your 65th birthday. But you may continue it each year until the Anniversary on or following your 75th birthday. This is provided you stay actively and gainfully employed full time, at least 30 hours a week.

You must tell us within 30 days before or after each Anniversary on or after your 65th birthday if you want to continue your policy. We may ask for proof that you're employed.

The maximum benefit period will be 12 months. We'll base the annual premium on your age and occupation then. Rates will be those we're using at that time.

If your active and gainful employment stops after we've continued your policy, coverage will end on the date you stop working. We'll refund any premiums paid for coverage after that date.

#### **PART 6—WHEN YOU'RE NOT COVERED**

*There are certain disabilities we don't cover. And there are times when we may suspend coverage. We discuss this in PART 6.*

**Disabilities not covered.** We don't cover disability caused or contributed to by:

- war (declared or not)
- normal pregnancy, except as described in the definition of "sickness".
- normal childbirth, except as described in the definition of "sickness".

**Suspended coverage while in military.** This policy will be suspended if and when you enter active military service. This applies to the military service of any country or international authority. This doesn't apply to active duty for training that lasts 90 days or less.

We'll refund that part of any premium paid for the suspended period.

If you're released from active duty within 5 years from the date you entered active military service, you may restore this policy. Make written application and pay the required premium within 90 days of your release from active duty. No proof of insurability is needed. Premiums will be at the same rates as if the policy hadn't been suspended.

The restored policy will cover only injuries that occur after the restoration date. Or sickness that first appears (makes itself known) more than 10 days after the restoration date.

The terms of the restored policy and riders will be the same as before suspension.

**Pre-existing Conditions Limitations.** A disability or loss caused by a pre-existing condition not described on your application for this policy will be covered if the disability or loss commences 2 years after the effective date, as provided under the General Rule "Contesting Your Policy" in Part 7. A disability or loss caused by a pre-existing condition which you fully and accurately described in your application will not be contested unless the condition was excluded from coverage by name or specific description.

#### **PART 7—GENERAL RULES**

*PART 7 contains general rules that apply.*

**The owner.** You (the insured) are the owner of this policy.

**The entire contract.** The entire contract consists of: The policy. The application. Any attached riders, endorsements and other papers.

**Changes.** Any change must be approved by an officer of our company. You must sign any change that restricts your policy. The change must be attached to the policy. Our agents cannot make changes or waive any provision.

**Assignments or transfers.** The benefits of this policy may be assigned. Any interest may be transferred. Our Home Office must receive written notice of the terms of the assignment or a copy of the assignment. If not, we won't take notice of the change. In any case, we won't be responsible for the validity of any assignment.

**Contesting your policy.** After this policy has been in force for a period of two years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become contestable as to the statements contained in the application.

We won't deny a claim for disability which starts after 2 years from the date of issue because a disease or physical condition existed before coverage began; unless excluded from coverage by name or specific description.

We won't contest your policy or deny a claim for disability caused by a disease or physical condition which you fully and accurately described in your application for coverage; unless the condition was excluded from coverage by name or specific description.

**Legal actions.** No legal action may be brought to recover on this policy within 60 days after written proof of loss has been given as required by this policy. No such action may be brought after the expiration of this applicable statute of limitations from the time written proof of loss is required to be given.

**Misstating your age or sex.** If you misstate your age or sex in your application, we'll change the benefit amounts. The changed amounts will be what your premiums would have bought if you had given your correct age or sex.

But we'll only be required to make a refund if at your correct age or sex we wouldn't have issued the policy at all. Or if at your correct age or sex, coverage would have ended before we accepted the premium. The refund will only cover premiums you paid for coverage you won't receive. We'll deduct any amounts we've paid you.

**State laws.** Any provision that, on the effective date, conflicts with state laws where you reside, is changed to meet the minimum requirements of those laws.

**ENDORSEMENT**

**CONNECTICUT MUTUAL LIFE INSURANCE COMPANY**

**ConnMuMatic**

**PREMIUM PAYMENT SERVICE**

For the purpose of collecting premiums under this policy we will be authorized to withdraw funds from your account. If we accept this authorization premiums will be paid on a monthly basis.

Premiums will be computed at a percentage of the annual premium. The percentage is shown below. They will be payable on the first day of each policy year and every month thereafter.

If this authorization is no longer in effect, premiums will be payable monthly to the next quarterly increment. They will be payable quarterly thereafter. You may elect to pay premiums annually or semi-annually as provided in the Policy.

All terms of the Policy will apply to premiums on a monthly basis.

The word "Policy" as used in this form also means "Contract".

Issued by Connecticut Mutual Life Insurance Company, 140 Garden Street, Hartford, Connecticut.

**CONNECTICUT MUTUAL LIFE INSURANCE COMPANY**

*Oia Flanagan*

Secretary

Percentage of Premium	Applies To
8.54%	Policies below #3,288,000
8.62%	Policies above #3,288,000
8.70%	86 Series

ENDORSEMENT

CHANGE OF INSURER NAME AND ADDRESS  
NOTICE OF ANNUAL MEETING

CONNECTICUT MUTUAL LIFE INSURANCE COMPANY ("Connecticut Mutual") and MASSACHUSETTS MUTUAL LIFE INSURANCE COMPANY ("MassMutual") have merged. MassMutual is the surviving company. As a result, MassMutual has succeeded to all liabilities, duties and rights of Connecticut Mutual. All references in this policy/contract to Connecticut Mutual are hereby changed to MassMutual.

The MassMutual Home Office is:

Massachusetts Mutual Life Insurance Company  
Springfield, Massachusetts 01111-0001  
1-800-272-2216

The back page of this policy/contract is hereby changed to add the following Notice of Annual Meeting:

The Insured/Annuitant is hereby notified that by virtue of this policy/contract he or she is a member of Massachusetts Mutual Life Insurance Company and is entitled to vote either in person or by proxy at any and all meetings of said Company. The annual meetings are held at its Home Office, in Springfield, Massachusetts on the second Wednesday of April in each year at 2 o'clock p.m.

The Endorsement forms a part of, and should be attached to, this policy/contract.

MASSACHUSETTS MUTUAL LIFE INSURANCE COMPANY

*Pia Flanagan*

Secretary



## Duplicate of Lost Policy

INSURED	POLICY NUMBER(S)
RICKY D GORDON	4750574

This policy is a duplicate of the original policy which has the same number and was prepared according to our current records. We issued this duplicate because we were furnished with evidence that the original policy was lost or destroyed.

If the original policy is ever found, it must be returned to us for cancellation.

This duplicate policy is issued under the terms of the Lost Policy Agreement filed with us at our Home Office.

10/31/2018

MASSACHUSETTS MUTUAL LIFE INSURANCE COMPANY

*Pia Flemagom*  
Secretary



169760

X Connecticut Mutual Life Insurance Company  
CM Life Insurance Company

## PART I

## COMBINATION LIFE AND DISABILITY APPLICATION

Life  
X Disability

PQSD

AGENCY NUMBER: 207

COMPLETE FOR ALL CASES

A1. PROPOSED INSURED

(first, middle, last)

RICKY D GORDON

A2. SEX:

Female

Male 

A3. Date of Birth:

Month Day Year

(Select one)

A5. INSURED'S SOCIAL SECURITY NO.

A4. Birth State:

NY

A7. POLICY OWNER NAME (If other than insured)

(first, middle, last)

A8. INSURED'S EMPLOYER NAME:

RICKY D GORDON PA

A9. (If less than 2 years with current employer)

INSURED'S FORMER EMPLOYER NAME

A10. ADDRESS

INSURED'S CURRENT RESIDENCE	NUMBER/STREET	760 N.W. 48 AVE NYC	
	CITY/STATE/ZIP CODE	COCONUT CREEK	Florida 33063
INSURED'S FORMER RESIDENCE	(If less than 2 years at current residence)		
	NUMBER/STREET		
	CITY/STATE/ZIP CODE		
EMPLOYER'S CURRENT ADDRESS	NUMBER/STREET	RICKY D. GORDON, PA	
	CITY/STATE/ZIP CODE	2842-A UNIVERSITY DRIVE	33065
EMPLOYER'S FORMER ADDRESS	(If less than 2 years with current employer)		
	NUMBER/STREET		
	CITY/STATE/ZIP CODE		
POLICY OWNER'S CURRENT ADDRESS	NUMBER/STREET		
	CITY/STATE/ZIP CODE		

## A11. PREMIUM NOTICES TO:

A. LIFE INSURANCE: Proposed Insured: Residence Employer Other (If other, indicate name and address below)  
 Policyowner: Residence Other

**PQSD**

Name:			
Number/Street:			
City/State/Zip Code:			

B. DISABILITY INCOME: Proposed Insured: Residence Employer Other (If other, indicate name and address below)

Name:	Rickey D. Gordon ESA		
Number/Street:	P.O. BOX 63-6410		
City/State/Zip Code:	MARGATE	FLORIDA	33063

A12. INSURED'S OCCUPATION TITLE: ATTORNEY

DUTIES: TRIAL PRACTICE

A13. How long employed in current job? Years 2 Months 0A14. Have you been actively at work daily on a full-time basis for the past 3 months? If no, explain.  
 (Disregard vacation days, normal non-working days and absences that total less than 7 days.) Yes       NoA15. Select One: Smoker Rate     Non-smoker Rate    Juvenile (0-15) Rate

COMPLETE FOR ALL INSURANCE: Write additional instructions and details of yes answers in space provided below.

A16. Do you plan to change your occupation? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	A24a. In the past three years have you been in a motor vehicle accident, or charged with a "moving" violation of any motor vehicle law or has your driver's license ever been suspended? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
A17. Do you plan any foreign residence or travel? If yes, submit supplement (F257). <input checked="" type="checkbox"/> Yes	b. State. Operator's license number <input checked="" type="checkbox"/> FL [REDACTED]
A18. In the past three years have you taken part in any avocation such as motor vehicle racing, parachute jumping, hang gliding, skin or scuba diving? Is such activity planned? If yes, submit Avocation Supplement. (F1093) <input checked="" type="checkbox"/> Yes	Details here:
A19. Within the past 3 years, have you flown as a pilot or crew member? If yes, submit Aviation Supplement. (F1093) <input checked="" type="checkbox"/> Yes	
A20. Do you plan to replace or change any life, or disability income now in force on your life? If yes, submit required documents. <input checked="" type="checkbox"/> Yes	
A21. Do you plan to pay for this policy by a policy loan on an existing policy? <input checked="" type="checkbox"/> Yes	
A22. Has any insurance contract on your life terminated in the last six months? <input checked="" type="checkbox"/> Yes	
A23. Is any application for life, disability, accident or health insurance pending or is the reinstatement of any policy pending? <input checked="" type="checkbox"/> Yes	

A25. PROPOSED INSURED'S PHONE NUMBER FOR PERSONAL HISTORY INTERVIEW CALL:

Home: ( ) \_\_\_\_\_ Preferred Time: \_\_\_\_\_ A.M. \_\_\_\_\_ P.M.  
 Business: (305) 573-3705 Ext. \_\_\_\_\_ Preferred Time: 9-5 Y.A.M. X P.M.

A26. ADDITIONAL INSTRUCTIONS FOR PHM CALL: \_\_\_\_\_

## CONNECTICUT MUTUAL COMPANIES, HARTFORD, CONNECTICUT 06154

Connecticut Mutual Life Insurance Company

G.M. Life Insurance Company (a stock life insurance company)

— Issuing company shown in Part I —

AGENCY NUMBER \_\_\_\_\_

## PART II OF APPLICATION

Proposed Insured *Ricky Richard Gordon* Birth Date: \_\_\_\_\_ Answer unless exam being made:  
 Height 6 ft. 4 in. Weight 170 lbs.

1. a. Name and address of your personal physician (if none, so state):

Name: *None*

Number/Street: \_\_\_\_\_

City/State/Zip Code: \_\_\_\_\_

**PQSD**

b. Date and reason last consulted? \_\_\_\_\_

c. What diagnosis was made and what treatment prescribed? (include type of treatment, medications, length of hospital stay)

2. Have you ever been treated for or had any known indication of:

- a. Disorder of eyes, ears, nose or throat?
- b. Dizziness, fainting, headache, seizures or convulsions, paralysis or stroke?
- c. Depression, mental or nervous disorder or attempted suicide?
- d. Infection, shortness of breath, persistent hoarseness or cough, blood spitting, bronchitis, pleurisy, asthma, emphysema, tuberculosis or chronic respiratory disorder?
- e. Chest discomfort or pain, palpitation, high blood pressure, rheumatic fever, heart murmur, heart attack or other disorder of the heart or blood vessels?
- f. Jaundice, intestinal bleeding, ulcer, hernia, colitis, diverticulitis, hemorrhoids, recurrent indigestion, pancreatitis or other disorder of the stomach, intestines, liver or gall bladder?
- g. Sugar, albumin, blood or pus in urine, stone or other disorder of kidney, bladder, prostate or reproductive organs?
- h. Diabetes, thyroid or other endocrine disorders?
- i. Neuritis, sciatica, rheumatism, arthritis, gout or disorder of the muscles or bones, including the spine, back or joints?
- j. Deformity, lameness or amputation?
- k. Disorder of skin, breasts, lymph glands, cyst, tumor or cancer?
- l. Allergies, immune disorder, venereal disease, anemia or other disorder of the blood?
- m. Alcoholism or drug use?

3. Are you now under observation or taking treatment? 4. Have you had any change in weight in the past year? 5. Have you smoked cigarettes at any time within the past 12 months? 

6. Other than above, have you within the past 5 years:

- a. Had any mental or physical disorder, illness, injury or surgery?
- b. Had a checkup or consultation or been a patient in a hospital, institution, clinic, sanatorium or other medical facility?
- c. Had electrocardiogram, X-ray or other diagnostic test?
- d. Been advised to have any diagnostic test, hospitalization or surgery which was not completed?

7. Have you ever requested or received a pension, benefits or payment, because of an injury, sickness or disability? 

8. Is there a family history (parents, brothers, sisters) of:

- a. Diabetes, kidney disease, cancer, mental illness or suicide?
- b. Heart disease, heart attack or angina, high blood pressure, stroke or any other disorder of the heart or blood vessels known before age 60?

I have read all statements and answers in this application (consisting of Parts One and Two and any amendments thereto) and represent that they are true and complete to the best of my knowledge and belief, and agree that they shall be the basis of and a part of the consideration for the Insurance applied for.

Signed at: *None* on *2-2-85*

City and State

Signature of Proposed

Insured or Parent if

Proposed Insured a Minor

Date

Witness: *D.J. Gordon, M.D.*(Signature of Examiner or Licensed Agent) *MAMMELA ROONICK, A.D.*

F11-86

## AMENDMENT TO PENDING APPLICATION

TO: Connecticut Mutual Companies, 140 Garden St., Hartford, Connecticut

JUN 16 REC'D

Proposed Insured:

RICKY D GORDON

FILE WITH *FILE NO. 750-574*  
Policy Number: JUN 16 REC'D Part 2, Dated FEB. 22, 1988 Agency: 8

The following changes and additional statements as indicated below are made with respect to application for insurance described above.

## Adjustable Benefit (AB)

With      Without

<input type="checkbox"/>	<input type="checkbox"/>	Adjustable Basic Monthly Benefit to:	\$ .....	Waiting Period-Days	Benefit Period-Duration
<input type="checkbox"/>	<input type="checkbox"/>	Adjustable Additional Monthly Benefit to:	\$ .....	.....	.....

## Non-Cancellable (NC)

With      Without

<input type="checkbox"/>	<input type="checkbox"/>		\$ .....	.....	.....
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## Guaranteed Continuable (GC)

With      Without

<input type="checkbox"/>	<input type="checkbox"/>	Section 1A to:	\$ .....	.....	.....
<input type="checkbox"/>	<input type="checkbox"/>	Section 1B to:	\$ .....	.....	.....
<input type="checkbox"/>	<input type="checkbox"/>	Section 2 to:	\$ .....	.....	.....

## Overhead Basic Monthly Benefit to:

With      Without

<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$ 2,500	90	1 YR
-------------------------------------	--------------------------	--	----------	----	------

## With      Without      Rider:

<input type="checkbox"/>	<input type="checkbox"/>	Lifetime Total Disability	\$ .....	.....	.....
<input type="checkbox"/>	<input type="checkbox"/>	COLA Rider Max ..... %	\$ .....	.....	.....
<input type="checkbox"/>	<input type="checkbox"/>	Partial Disability	\$ .....	.....	.....
<input type="checkbox"/>	<input type="checkbox"/>	Social Security Supplement	\$ .....	.....	.....
<input type="checkbox"/>	<input type="checkbox"/>	Extended Benefit	\$ .....	.....	.....
<input type="checkbox"/>	<input type="checkbox"/>	Extended Term	\$ .....	.....	.....
<input type="checkbox"/>	<input type="checkbox"/>	Short Term A	\$ .....	.....	.....
<input type="checkbox"/>	<input type="checkbox"/>	Short Term B	\$ .....	.....	.....
<input type="checkbox"/>	<input type="checkbox"/>	Insurability	\$ .....	.....	.....
<input type="checkbox"/>	<input type="checkbox"/>	Own Occupation	\$ .....	.....	.....

The request for non-smoker rate is hereby withdrawn.

I am not currently disabled.

Coverage with \_\_\_\_\_ Company will be permanently discontinued effective within 60 days from the issue date of this policy.

An additional policy of \_\_\_\_\_ monthly benefit to be issued on the same terms and conditions and to include the same provisions as specified in the prior application.

Application is hereby made for an extra premium class disability income policy to be issued with a monthly income and premium schedule as specified on the Coverage Page of the policy.

Riders issued under this policy shall also carry an extra premium class rating.

Except as changed above, my answers and statements to application Parts One and Two are true and complete. They are true and complete to the best of my knowledge and belief as of made at the time I sign this amendment. A copy of my application is attached. Other than to comply with the Company's underwriting requirements, I have not sought or received medical advice or treatment since the date of the Part Two.

is agreed by the undersigned that these changes and statements shall be incorporated in the application referred to above as fully and completely as if they had been originally set forth therein, and shall be subject in all respects to the agreements contained in the application.

Agreed at: *COCONUT CREEK, Florida* on *6-4-88*  
City and State: *Florida* Date: *6-4-88*

Please  
Sign *R.D.G.*

Applicant — If other than proposed Insured

Proposed Insured

**BUSINESS OVERHEAD EXPENSE POLICY**

Noncancelable—Rates guaranteed

Guaranteed continuable to age 65

Conditionally continuable to age 75

Subject to premium change

Participating in dividends

**Connecticut Mutual Life Insurance Company**  
Hartford, Connecticut • Since 1846

Insured

Policy Number

We at Connecticut Mutual Life believe you should read your policy. We've written it in plain English so you'll understand its terms. We will, subject to these terms, pay the benefits to you if you become disabled after the effective date.

**Benefits this policy provides**

- Business overhead expense payments during total disability
- Income during partial disability
- Premium waived during disability
- Dividends
- Conditional right to continue the policy to age 75

Your policy is issued in consideration of your application and premium payments. A copy of your application is attached and made a part of this policy.

We provide benefits for a loss arising from a sickness or disease that first appears (makes itself known) on or after the effective date and while this policy is in force. We also provide benefits for a loss resulting from an accidental bodily injury that happens on or after the effective date.

We won't cancel this policy. Nor will we increase the premiums. As long as you pay premiums on time, we'll continue coverage until the Anniversary on or following your 65th birthday.

**Policy Index**

PART 1 Definitions

PART 2 Disability benefits

PART 3 Premiums

PART 4 Claims

PART 5 Other benefits

PART 6 When you're not covered

PART 7 General rules

Ten day right to examine. If for any reason you decide not to keep this policy, send it to us within 10 days after receiving it. Send it to our Home Office or to the agent who sold it to you. We'll treat the policy as though it never had been issued. We'll refund any premium paid.

This policy is issued by Connecticut Mutual Life Insurance Company at our Home Office, 140 Garden Street, Hartford, Connecticut 06154 on the effective date.

*Oja Flemagem*

Secretary

*M. W. [Signature]*

President

Registrar

Countersigned  
by \_\_\_\_\_ Licensed Resident Agent

**EXHIBIT C**

**BUSINESS OVERHEAD EXPENSE POLICY**

Noncancelable—Rates guaranteed

Guaranteed continuable to age 65

Conditionally continuable to age 75

Subject to premium change

Participating in dividends

## COVERAGE PAGE

INSURED RICKY D GORDON

6014736 POLICY NUMBER

## DISABILITY INCOME POLICY

DATE OF ISSUE	SEP 2, 1999	AGE	44			
DATE OF REISSUE	OCT 29, 2018					
EFFECTIVE DATE	COVERAGE	MONTHLY BENEFIT	WAITING PERIOD	MAXIMUM BENEFIT PERIOD	ANNUAL PREMIUM	PAYABLE TO YEAR
SEP 2 1999	MONTHLY OVERHEAD EXPENSE BENEFIT	\$2,500	90 DAYS	1 YEAR	\$191.25	2019
YOUR MAXIMUM MONTHLY BENEFIT IS \$2,500		TOTAL ANNUAL PREMIUM			\$191.25	
		MONTHLY PREMIUM			\$16.49	

IT IS ANTICIPATED THAT DIVIDENDS WILL BE PAYABLE AFTER 2 YEARS AND MAY BE USED AS DESCRIBED IN YOUR POLICY.

YOUR PREMIUM IS BASED ON NON-SMOKER RATES, DISCOUNTED BY 10% FROM THE SMOKER RATES.

**PART 1—DEFINITIONS**

*In PART 1, we define several terms used in this policy.*

**Effective date:** The date that the policy is "in effect." Coverage starts on that date. An Anniversary falls each year on the same month and day as the effective date.

**Elimination period:** The number of days immediately following the start of your disability. No benefits are provided during the elimination period. Your elimination period is shown on the Coverage Page.

**Maximum benefit period:** The maximum length of time we'll pay benefits.

**Sickness:** A sickness or disease that first appears (makes itself known) on or after the effective date. It includes disability from the transplant of a part of your body to the body of another and complications of pregnancy. After you have been totally disabled for 90 days, normal pregnancy and normal childbirth, for a pregnancy having its inception on or after the effective date, will be considered a sickness.

**Injury:** An accidental bodily injury that happens on or after the effective date.

**Occupation:** Your regular occupation at the start of disability.

**Doctor:** A licensed medical practitioner other than the insured.

**Income:** Gross earnings from any job or business. This doesn't include:

- Investment income.
- Rent.
- Royalties.
- Any amount which is deductible from gross income as a business expense for income tax purposes.

**Unearned Income:** All income which is not gross earnings from any job or business. This may include, but is not limited to:

- Investment income.
- Rent.
- Royalties.

**Proof of insurability:** Proof you give us, or that we might obtain, that you're an acceptable risk.

**Assignment:** Legal transfer of one's interest to another party.

**Pre-existing Condition:** A pre-existing condition is a physical condition or sickness which during the 5 year period prior to the effective date of this policy, caused the insured to have received medical advice or treatment.

**Overhead expenses:** Expenses you normally have in running your office or business. These expenses include, but are not limited to:

Rent	Electricity
Heat and water	Telephone
Interest payments on the business premises you own and use in running your business	Cost of leasing equipment
Employees' salaries (except as limited below)	Laundry
	Depreciation

Overhead expenses do not include:

Cost of goods for sale

Additions to inventory

Cost of tools, instruments or wares used in your profession or occupation.

Mortgage principal payments.

If overhead expenses are shared with one or more persons, we only cover your portion of the expenses.

**PART 2—DISABILITY BENEFITS**

*In PART 2, we discuss the different kinds of disability covered and the benefits we provide.*

**The kinds of disability covered**

**Total disability:** You're totally disabled if because of sickness or injury you can't do the main duties of your occupation. And you must be under a doctor's care.

You must be totally disabled for the full elimination period. We'll pay the first monthly benefit one month after the elimination period ends.

**Presumptive total disability:** If sickness or injury results in the total loss of sight, speech or hearing or the total loss of use of both hands, both feet, or one hand and one foot, it will be considered total disability while it continues. The requirement that you must be under a doctor's care will be waived.

**Partial disability:** You're partially disabled if because of sickness or injury:

- you can do some, but not all the duties of your occupation, or
- you can work at your occupation no more than 3/4 the hours you worked before becoming disabled

In either case, you must be under a doctor's care.

**Recurring disability:** This is a related disability that starts less than 6 months after a period of total or partial disability. We will treat the recurring disability as a continuation of the prior one. If the elimination period has already been satisfied, no new elimination period is required. If the elimination period has not been satisfied, periods of recurring disability may be accumulated to satisfy the elimination period.

*(Example: Bob's policy has a one-month elimination period for total disability. He has a stomach ulcer attack and is totally disabled for more than one month. Two months after returning to work, Bob has a second stomach ulcer attack and is totally disabled again for 2 months. The second attack is treated as a continuation of the first. So, Bob will start to receive total benefits without another elimination period.)*

**The benefits provided for disability**

**Total disability benefit—business overhead expense benefit.** Each monthly benefit we pay will either be equal to your share of the actual business overhead expenses, or be in the amount shown on the Coverage Page, whichever is less.

You will get benefits for as long as you are totally disabled, up to the maximum benefit period. If your actual expenses are less than the amount shown on the Coverage Page, we will extend benefits beyond the maximum benefit period. We will pay until the total benefit paid equals your monthly overhead expense benefit times your maximum benefit period. In no event, will we pay beyond the sixth month after the end of your maximum benefit period.

*(Example: Your monthly overhead expense benefit is \$1,000. Your maximum benefit period is 12 months. Your actual overhead expenses during 12 months came to \$10,000 and this is what we paid to the end of the maximum benefit period. We'll extend benefits until we pay another \$2,000 (\$12,000 - \$10,000). But we won't pay beyond the sixth month after the end of your maximum benefit period.)*

You won't get a larger benefit if you're disabled due to more than one cause.

**Partial disability benefit—business overhead expense benefit.** Benefits will start after the elimination period shown on the Coverage Page. We'll pay the first monthly benefit 1 month after the elimination period ends. We'll pay benefits up to the 12th month following the start of your disability.

The amount of your partial disability benefit will be 1/2 the total disability benefit.

We'll pay the partial disability benefit if you meet all the following conditions:

- You're totally and/or partially disabled for the elimination period shown on the Coverage Page
- Your total disability benefits, if they were payable, have ended
- You're partially disabled but not totally disabled.

**PART 3—PREMIUMS**

*The annual premium is shown on the Coverage Page. In PART 3 we tell how, when and where to pay premiums.*

**Premium payments.** Premiums are due in advance. The first is due on the effective date. Premiums after the first are due on the same day of the month as the effective date. Premiums may be paid annually. Or they may be paid more frequently as we allow. They must be paid to our Home Office or to one of our authorized agents.

**Grace period.** Each premium after the first must be paid within 31 days after its due date. This 31 day period is called the "grace period." The policy will stay in effect during the grace period.

**Changing when you pay.** You may request a change in the frequency of your payments on any Anniversary. This request must be in writing. Any change is subject to our approval.

**Refund after death.** We'll refund any premium that was paid for coverage after the policy month in which you die. Our Home Office must first receive written notice of your death.

**PART 4—CLAIMS**

*There are certain things you must do when making a claim. In PART 4, we discuss these requirements. We also discuss payment of claims.*

**How to make a claim**

**Notice of disability.** Send a written notice of your disability to our Home Office or to one of our authorized agents. Send it within 20 days after the start of disability, or as soon as reasonably possible. There's no required form.

**Claim forms.** We'll then send you a claim form. If you don't receive one within 15 days after you sent notice, write us your own claim letter. Tell us what caused the disability. Describe your situation.

**Required proof.** Whether on our claim form or your claim

letter, send proof of your disability and any proof of monthly overhead expenses that may be required. Send it to our Home Office as soon as possible. Required proof must also be received within 90 days of each monthly benefit payment claimed. If it's not possible to send it within 90 days, send it as soon as reasonably possible. Your claim won't be reduced because of the delay. But we won't accept proof of loss later than 1 year after it was due. We'll make an exception if you weren't then competent to make the claim.

We may require from time to time that you be examined by doctors we choose. We'll pay the cost. We may also require from time to time, satisfactory proof of your expenses before and during disability.

**Payment of claims**

**When benefits are paid.** We'll pay benefits monthly.

**Whom we'll pay.** We'll pay benefits to you. If you're a minor or not competent to give a release, we may pay up to \$3,000 to any relative of yours who we believe is entitled.

**If you die,** we'll pay your estate all amounts due prior to your death. But we may pay up to \$3,000 to any relative of yours who we believe is entitled.

Any payment we make in good faith will fully discharge us for that payment.

**Part payments.** Let us know as soon as you've recovered. If you recover during a month, we'll send you a pro-rata payment for the part of the month you were disabled.

**PART 5—OTHER BENEFITS**

*In PART 5, we discuss other benefits we provide.*

**Waiver of premiums.** We'll waive all premiums that come due after you've been totally and/or partially disabled for 90 days from the same sickness or injury. You won't have to pay premiums that come due while you remain disabled. We won't waive premiums beyond the maximum benefit period. We'll refund any premium paid for a period up to 90 days before you qualify for this benefit.

We'll waive premiums for this policy and any attached riders.

We'll waive premiums on the payment mode in effect when you become disabled.

**Exchange Privilege.** If, prior to attained age 60, you wish to apply to exchange this policy for one that provides benefits unrelated to business overhead expenses, you may make the exchange without producing additional evidence of good health or the nature of your occupation. The statements you made in your application for this policy will also apply to the new policy. You will have to prove that you are employed. You must not be totally or partially disabled.

The right to exchange your policy will be subject to the company's published limits of maximum monthly benefit based on your income, unearned income and other disability income coverage you may own. We may change these limits from time to time. If we do, you may elect to use the limits in effect when you purchased your original coverage or our new limits if higher. Your unearned income will be taken into consideration only if it exceeds the percentage published in our underwriting rules.

Subject to our published limits, the monthly benefit and elimination period under the new policy will be the same as the monthly benefit and elimination period on the Coverage Page of this policy. The new policy will be issued on the policy form the company then uses to provide total and partial disability benefits unrelated to business overhead expenses to new policyholders in the occupation described in the application for this policy. The maximum benefit period for the new policy will be two years. The cost of your new policy will be based on the rates new policyholders pay at the age when you apply for the exchange. The new policy may contain the same exclusions for diseases or physical conditions that this policy contained, if appropriate. Conversion will be made effective on the date of the application. Any unearned premium under this policy will be returned.

Upon exchange, we'll measure the time period stated in the "Contesting your policy" provision of any new policy from the issue date of that policy. If this policy can't be contested,

we can only use misstatements in the application for the new policy to contest that policy.

**Dividends.** Each year we determine how much can be paid as dividends on our policies. We call this "the divisible surplus". Then we figure how much of the divisible surplus can be paid as a dividend on all policies like yours.

We'll pay any dividends on the Anniversaries. We don't expect that there will be any before the second Anniversary.

We pay dividends in cash. But if you ask, we'll apply them toward premiums. Or, we'll accumulate them for you. We'll accumulate dividends at an interest rate of not less than 3% a year. We don't credit interest for any part of a year.

**Payment of premiums by accumulated dividends.** If you request it in the application, or in writing while this policy is premium paying, we'll automatically use accumulated dividends, if sufficient, to pay any premium in default. This also applies to the premium for any benefit rider attached to this policy.

**Reinstating the policy.** The policy will end if premiums are not paid when due or within the grace period.

If we don't require an application and evidence of your good health, you may reinstate the policy (restore coverage) by paying the back premiums. Pay us or one of our authorized agents. The reinstatement date will be the date you pay the back premiums.

If we do require an application, you'll have to pay back premiums and provide evidence of your good health. Then the reinstatement date will be the date that we approve your application. If you aren't notified of either approval or disapproval, the policy will be reinstated 45 days after the date of your application.

The reinstated policy will cover injuries that occur after the reinstatement date. It will cover sickness that first appears (makes itself known) more than 10 days after the reinstatement date.

After reinstatement, the terms of the policy and attached riders will be the same as before termination. Except for terms added in connection with reinstatement.

**Conditions for continuing the policy to age 75.** This policy ends on the Anniversary on or following your 65th birthday. But you may continue it each year until the Anniversary on or following your 75th birthday. This is provided you stay actively and gainfully employed full time, at least 30 hours a week.

You must tell us within 30 days before or after each Anniversary on or after your 65th birthday if you want to continue your policy. We may ask for proof that you're employed.

The maximum benefit period will be 12 months. We'll base the annual premium on your age and occupation then. Rates will be those we're using at that time.

If your active and gainful employment stops after we've continued your policy, coverage will end on the date you stop working. We'll refund any premiums paid for coverage after that date.

## PART 6—WHEN YOU'RE NOT COVERED

*There are certain disabilities we don't cover. And there are times when we may suspend coverage. We discuss this in PART 6.*

**Disabilities not covered.** We don't cover disability caused or contributed to by:

- war (declared or not)
- normal pregnancy, except as described in the definition of "sickness".
- normal childbirth, except as described in the definition of "sickness".

**Suspended coverage while in military.** This policy will be suspended if and when you enter active military service. This applies to the military service of any country or international authority. This doesn't apply to active duty for training that lasts 90 days or less.

We'll refund that part of any premium paid for the suspended period.

If you're released from active duty within 5 years from the date you entered active military service, you may restore this policy. Make written application and pay the required premium within 90 days of your release from active duty. No proof of insurability is needed. Premiums will be at the same rates as if the policy hadn't been suspended.

The restored policy will cover only injuries that occur after the restoration date. Or sickness that first appears (makes itself known) more than 10 days after the restoration date.

The terms of the restored policy and riders will be the same as before suspension.

**Pre-existing Conditions Limitations.** A disability or loss caused by a pre-existing condition not described on your application for this policy will be covered if the disability or loss commences 2 years after the effective date, as provided under the General Rule "Contesting Your Policy" in Part 7. A disability or loss caused by a pre-existing condition which you fully and accurately described in your application will not be contested unless the condition was excluded from coverage by name or specific description.

## PART 7—GENERAL RULES

*PART 7 contains general rules that apply.*

**The owner.** You (the insured) are the owner of this policy.

**The entire contract.** The entire contract consists of: The policy. The application. Any attached riders, endorsements and other papers.

**Changes.** Any change must be approved by an officer of our company. You must sign any change that restricts your policy. The change must be attached to the policy. Our agents cannot make changes or waive any provision.

**Assignments or transfers.** The benefits of this policy may be assigned. Any interest may be transferred. Our Home Office must receive written notice of the terms of the assignment or a copy of the assignment. If not, we won't take notice of the change. In any case, we won't be responsible for the validity of any assignment.

**Contesting your policy.** After this policy has been in force for a period of two years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become contestable as to the statements contained in the application.

We won't deny a claim for disability which starts after 2 years from the date of issue because a disease or physical condition existed before coverage began; unless excluded from coverage by name or specific description.

We won't contest your policy or deny a claim for disability caused by a disease or physical condition which you fully and accurately described in your application for coverage; unless the condition was excluded from coverage by name or specific description.

**Legal actions.** No legal action may be brought to recover on this policy within 60 days after written proof of loss has been given as required by this policy. No such action may be brought after the expiration of this applicable statute of limitations from the time written proof of loss is required to be given.

**Misstating your age or sex.** If you misstate your age or sex in your application, we'll change the benefit amounts. The changed amounts will be what your premiums would have bought if you had given your correct age or sex.

But we'll only be required to make a refund if at your correct age or sex we wouldn't have issued the policy at all. Or if at your correct age or sex, coverage would have ended before we accepted the premium. The refund will only cover premiums you paid for coverage you won't receive. We'll deduct any amounts we've paid you.

**State laws.** Any provision that, on the effective date, conflicts with state laws where you reside, is changed to meet the minimum requirements of those laws.

**ENDORSEMENT**

**CONNECTICUT MUTUAL LIFE INSURANCE COMPANY**

**ConnMuMatic**

**PREMIUM PAYMENT SERVICE**

For the purpose of collecting premiums under this policy we will be authorized to withdraw funds from your account. If we accept this authorization premiums will be paid on a monthly basis.

Premiums will be computed at a percentage of the annual premium. The percentage is shown below. They will be payable on the first day of each policy year and every month thereafter.

If this authorization is no longer in effect, premiums will be payable monthly to the next quarterly increment. They will be payable quarterly thereafter. You may elect to pay premiums annually or semi-annually as provided in the Policy.

All terms of the Policy will apply to premiums on a monthly basis.

The word "Policy" as used in this form also means "Contract".

Issued by Connecticut Mutual Life Insurance Company, 140 Garden Street, Hartford, Connecticut.

**CONNECTICUT MUTUAL LIFE INSURANCE COMPANY**

*Pia Flanagan*

Secretary

Percentage of Premium	Applies To
8.54%	Policies below #3,288,000
8.62%	Policies above #3,288,000
8.70%	86 Series

ENDORSEMENT

CHANGE OF INSURER NAME AND ADDRESS  
NOTICE OF ANNUAL MEETING

CONNECTICUT MUTUAL LIFE INSURANCE COMPANY ("Connecticut Mutual") and MASSACHUSETTS MUTUAL LIFE INSURANCE COMPANY ("MassMutual") have merged. MassMutual is the surviving company. As a result, MassMutual has succeeded to all liabilities, duties and rights of Connecticut Mutual. All references in this policy/contract to Connecticut Mutual are hereby changed to MassMutual.

The MassMutual Home Office is:

Massachusetts Mutual Life Insurance Company  
Springfield, Massachusetts 01111-0001  
1-800-272-2216

The back page of this policy/contract is hereby changed to add the following Notice of Annual Meeting:

The Insured/Annuitant is hereby notified that by virtue of this policy/contract he or she is a member of Massachusetts Mutual Life Insurance Company and is entitled to vote either in person or by proxy at any and all meetings of said Company. The annual meetings are held at its Home Office, in Springfield, Massachusetts on the second Wednesday of April in each year at 2 o'clock p.m.

The Endorsement forms a part of, and should be attached to, this policy/contract.

MASSACHUSETTS MUTUAL LIFE INSURANCE COMPANY

*Pia Flanagan*

Secretary

Agency No.

## Application For Additional Disability Income Benefits

Connecticut Mutual Life Insurance Company, Hartford, Connecticut

IDENTIFICATION	1. A. The Name of the Insured is: (first, middle, last)		R I C K Y   D   G O R D O N				
	B. Sex	C. You were born on: (mo, day, yr)	D. Your birth state is:	E. Your residence state is:	F. Your business state is:		
<input checked="" type="checkbox"/> M <input type="checkbox"/> F	██████████	N.Y.	FLORIDA	FLORIDA			
G. Policy Number(s) affected by this application:		41750, 574		██████████			
				H. Your Social Security number is: ██████████			

Complete Questions #2—10 for both an option under an adjustable benefit contract or an option under an additional benefits rider.

INSURABILITY	2. The Amount of the Additional Benefit is: \$... <u>2,500</u> .....					6. Are you currently disabled? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	3. In what state are you employed? <u>Penns</u>					7. A. Will your employer continue salary or other payments if you are disabled? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	4. Existing Total Disability, Accident and Health Insurance <u>0/0</u>					B. If yes, how much per month? \$.....
	Source or Company	Monthly Income	Benefit Period	Period	Year	C. How long? ..... months.
	Conn. Mutual	<u>750</u>	<u>75.00</u>	<u>12 months</u>	<u>12 months</u>	8. A. Your annual earned income after business expenses but before taxes <u>1/3</u> \$.....
	Total	<u>7500</u>	<u>750</u>			B. All other annual income \$.....
	5. Is the employer paying the premium under a qualified plan? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					9. The Amount of the Prepayment is: (must be prepaid) \$..... <u>16.49</u> .....
						10. Have you smoked cigarettes within the last 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Complete Questions #11–15 only for an option under an additional benefits rider.

POLICY INFORMATION	11. <input checked="" type="checkbox"/> Regular Option	
	<input type="checkbox"/> Alternate Option for marriage, or after birth or adoption of a child: I was married to _____ <small>(Name of spouse)</small> ON _____ <small>(Date)</small>	
	I am the parent of _____ <small>(Name of child)</small> as of _____ <small>(Birth or adoption date)</small>	
12. Premiums are payable: <input type="checkbox"/> A <input type="checkbox"/> SA <input type="checkbox"/> Q <input checked="" type="checkbox"/> MCS <input type="checkbox"/> Allot		14. Dividends: <input type="checkbox"/> Applied <input checked="" type="checkbox"/> Cash <input type="checkbox"/> Accumulate
13. APD <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		15. Do you have dependent children? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

COMMENTS	16.

This Application is made in accordance with and subject to the provisions of the insurability agreement contained in the above policy. No agent may change the terms of this application or any coverage issued by the Company. And no agent may waive any of the Company's rights or requirements. If the date of issue of the coverage applied for is within two years of the Date of Issue of the Adjustable Benefit contract, or the additional benefits rider, the undersigned represent(s) the statements and answers pertaining to the insurability of the proposed insured in the Application for that policy or rider were as of its date true and complete to the best knowledge and belief of the undersigned. The original Application shall form a part of this Application. This is agreed by the undersigned. Receipt of a Notice of Insurance Information Practices is hereby acknowledged.

Signed at Colombia Springs, Co. on 1/1/1959

Witnessed by \_\_\_\_\_ Signature of \_\_\_\_\_  
Soliciting Agent \_\_\_\_\_ Proposed Insured \_\_\_\_\_

Signature of  
Proposed Insured . . . . .  
Signature of Owner of  
Original Policy if other  
than Proposed Insured . . . . .

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**BUSINESS OVERHEAD EXPENSE POLICY**

Noncancelable—Rates guaranteed  
Guaranteed continuable to age 65  
Conditionally continuable to age 75  
Subject to premium change  
Participating in dividends

**Connecticut Mutual Life Insurance Company**  
Hartford, Connecticut • Since 1846

Insured

Policy Number

We at Connecticut Mutual Life believe you should read your policy. We've written it in plain English so you'll understand its terms. We will, subject to these terms, pay the benefits to you if you become disabled after the effective date.

**Benefits this policy provides**

- Business overhead expense payments during total disability
- Income during partial disability
- Premium waived during disability
- Dividends
- Conditional right to continue the policy to age 75

Your policy is issued in consideration of your application and premium payments. A copy of your application is attached and made a part of this policy.

We provide benefits for a loss arising from a sickness or disease that first appears (makes itself known) on or after the effective date and while this policy is in force. We also provide benefits for a loss resulting from an accidental bodily injury that happens on or after the effective date.

We won't cancel this policy. Nor will we increase the premiums. As long as you pay premiums on time, we'll continue coverage until the Anniversary on or following your 65th birthday.

**Policy Index**

- PART 1 Definitions
- PART 2 Disability benefits
- PART 3 Premiums
- PART 4 Claims
- PART 5 Other benefits
- PART 6 When you're not covered
- PART 7 General rules

**Ten day right to examine.** If for any reason you decide not to keep this policy, send it to us within 10 days after receiving it. Send it to our Home Office or to the agent who sold it to you. We'll treat the policy as though it never had been issued. We'll refund any premium paid.

This policy is issued by Connecticut Mutual Life Insurance Company at our Home Office, 140 Garden Street, Hartford, Connecticut 06154 on the effective date.

*Pia Flanagan*

Secretary

*My W. Lee*

President

Registrar

Countersigned  
by \_\_\_\_\_ Licensed Resident Agent

**EXHIBIT D****BUSINESS OVERHEAD EXPENSE POLICY**

Noncancelable—Rates guaranteed

Guaranteed continuable to age 65

Conditionally continuable to age 75

Subject to premium change

Participating in dividends



**COVERAGE PAGE**

INSURED RICKY D GORDON

4963278 POLICY NUMBER

## DISABILITY INCOME POLICY

DATE OF ISSUE JUL 31, 1991  
DATE OF RE-ISSUE OCT 29, 2018

AGE 36

EFFECTIVE DATE	COVERAGE	MONTHLY BENEFIT	WAITING PERIOD	MAXIMUM BENEFIT PERIOD	ANNUAL PREMIUM	PAYABLE TO YEAR
AUG 1 1991	MONTHLY OVERHEAD EXPENSE BENEFIT	\$2,500	90 DAYS	1 YEAR	\$123.75	2019

IT IS ANTICIPATED THAT DIVIDENDS WILL BE PAYABLE AFTER 2 YEARS AND MAY BE USED AS DESCRIBED IN YOUR POLICY.

YOUR PREMIUM IS BASED ON NON-SMOKER RATES, DISCOUNTED BY 10% FROM THE SMOKER RATES.

**PART 1—DEFINITIONS**

*In PART 1, we define several terms used in this policy.*

**Effective date:** The date that the policy is "in effect." Coverage starts on that date. An Anniversary falls each year on the same month and day as the effective date.

**Elimination period:** The number of days immediately following the start of your disability. No benefits are provided during the elimination period. Your elimination period is shown on the Coverage Page.

**Maximum benefit period:** The maximum length of time we'll pay benefits.

**Sickness:** A sickness or disease that first appears (makes itself known) on or after the effective date. It includes disability from the transplant of a part of your body to the body of another and complications of pregnancy. After you have been totally disabled for 90 days, normal pregnancy and normal childbirth, for a pregnancy having its inception on or after the effective date, will be considered a sickness.

**Injury:** An accidental bodily injury that happens on or after the effective date.

**Occupation:** Your regular occupation at the start of disability.

**Doctor:** A licensed medical practitioner other than the insured.

**Income:** Gross earnings from any job or business. This doesn't include:

- Investment income.
- Rent.
- Royalties.
- Any amount which is deductible from gross income as a business expense for income tax purposes.

**Unearned Income:** All income which is not gross earnings from any job or business. This may include, but is not limited to:

- Investment income.
- Rent.
- Royalties.

**Proof of insurability:** Proof you give us, or that we might obtain, that you're an acceptable risk.

**Assignment:** Legal transfer of one's interest to another party.

**Pre-existing Condition:** A pre-existing condition is a physical condition or sickness which during the 5 year period prior to the effective date of this policy, caused the insured to have received medical advice or treatment.

**Overhead expenses:** Expenses you normally have in running your office or business. These expenses include, but are not limited to:

Rent	Electricity
Heat and water	Telephone
Interest payments on the business premises you own and use in running your business	Cost of leasing equipment
Employees' salaries (except as limited below)	Laundry
	Depreciation

Overhead expenses do not include:

Salaries, fees, drawing accounts or other compensation received by any family member, colleague or partner working for or with you.

Cost of goods for sale

Additions to inventory

Cost of tools, instruments or wares used in your profession or occupation.

Any kind of expense which you didn't have in running your office or business immediately before becoming totally disabled.

Mortgage principal payments.

If overhead expenses are shared with one or more persons, we only cover your portion of the expenses.

**PART 2—DISABILITY BENEFITS**

*In PART 2, we discuss the different kinds of disability covered and the benefits we provide.*

**The kinds of disability covered**

**Total disability:** You're totally disabled if because of sickness or injury you can't do the main duties of your occupation. And you must be under a doctor's care.

You must be totally disabled for the full elimination period. We'll pay the first monthly benefit one month after the elimination period ends.

**Presumptive total disability:** If sickness or injury results in the total loss of sight, speech or hearing or the total loss of use of both hands, both feet, or one hand and one foot, it will be considered total disability while it continues. The requirement that you must be under a doctor's care will be waived.

**Partial disability:** You're partially disabled if because of sickness or injury:

- you can do some, but not all the duties of your occupation, or
- you can work at your occupation no more than 3/4 the hours you worked before becoming disabled

In either case, you must be under a doctor's care.

**Recurring disability:** This is a related disability that starts less than 6 months after a period of total or partial disability. We will treat the recurring disability as a continuation of the prior one. If the elimination period has already been satisfied, no new elimination period is required. If the elimination period has not been satisfied, periods of recurring disability may be accumulated to satisfy the elimination period.

*(Example: Bob's policy has a one-month elimination period for total disability. He has a stomach ulcer attack and is totally disabled for more than one month. Two months after returning to work, Bob has a second stomach ulcer attack and is totally disabled again for 2 months. The second attack is treated as a continuation of the first. So, Bob will start to receive total benefits without another elimination period.)*

**The benefits provided for disability**

**Total disability benefit—business overhead expense benefit.** Each monthly benefit we pay will either be equal to your share of the actual business overhead expenses, or be in the amount shown on the Coverage Page, whichever is less.

You will get benefits for as long as you are totally disabled, up to the maximum benefit period. If your actual expenses are less than the amount shown on the Coverage Page, we will extend benefits beyond the maximum benefit period. We will pay until the total benefit paid equals your monthly overhead expense benefit times your maximum benefit period. In no event, will we pay beyond the sixth month after the end of your maximum benefit period.

*(Example: Your monthly overhead expense benefit is \$1,000. Your maximum benefit period is 12 months. Your actual overhead expenses during 12 months came to \$10,000 and this is what we paid to the end of the maximum benefit period. We'll extend benefits until we pay another \$2,000 (\$12,000 - \$10,000). But we won't pay beyond the sixth month after the end of your maximum benefit period.)*

You won't get a larger benefit if you're disabled due to more than one cause.

**Partial disability benefit—business overhead expense benefit.** Benefits will start after the elimination period shown on the Coverage Page. We'll pay the first monthly benefit 1 month after the elimination period ends. We'll pay benefits up to the 12th month following the start of your disability.

The amount of your partial disability benefit will be 1/2 the total disability benefit.

We'll pay the partial disability benefit if you meet all the following conditions:

- You're totally and/or partially disabled for the elimination period shown on the Coverage Page
- Your total disability benefits, if they were payable, have ended
- You're partially disabled but not totally disabled.

**PART 3—PREMIUMS**

*The annual premium is shown on the Coverage Page. In PART 3 we tell how, when and where to pay premiums.*

**Premium payments.** Premiums are due in advance. The first is due on the effective date. Premiums after the first are due on the same day of the month as the effective date. Premiums may be paid annually. Or they may be paid more frequently as we allow. They must be paid to our Home Office or to one of our authorized agents.

**Grace period.** Each premium after the first must be paid within 31 days after its due date. This 31 day period is called the "grace period." The policy will stay in effect during the grace period.

**Changing when you pay.** You may request a change in the frequency of your payments on any Anniversary. This request must be in writing. Any change is subject to our approval.

**Refund after death.** We'll refund any premium that was paid for coverage after the policy month in which you die. Our Home Office must first receive written notice of your death.

**PART 4—CLAIMS**

*There are certain things you must do when making a claim. In PART 4, we discuss these requirements. We also discuss payment of claims.*

**How to make a claim**

**Notice of disability.** Send a written notice of your disability to our Home Office or to one of our authorized agents. Send it within 20 days after the start of disability, or as soon as reasonably possible. There's no required form.

**Claim forms.** We'll then send you a claim form. If you don't receive one within 15 days after you sent notice, write us your own claim letter. Tell us what caused the disability. Describe your situation.

**Required proof.** Whether on our claim form or your claim

letter, send proof of your disability and any proof of monthly overhead expenses that may be required. Send it to our Home Office as soon as possible. Required proof must also be received within 90 days of each monthly benefit payment claimed. If it's not possible to send it within 90 days, send it as soon as reasonably possible. Your claim won't be reduced because of the delay. But we won't accept proof of loss later than 1 year after it was due. We'll make an exception if you weren't then competent to make the claim.

We may require from time to time that you be examined by doctors we choose. We'll pay the cost. We may also require from time to time, satisfactory proof of your expenses before and during disability.

**Payment of claims**

**When benefits are paid.** We'll pay benefits monthly.

**Whom we'll pay.** We'll pay benefits to you. If you're a minor or not competent to give a release, we may pay up to \$3,000 to any relative of yours who we believe is entitled.

**If you die,** we'll pay your estate all amounts due prior to your death. But we may pay up to \$3,000 to any relative of yours who we believe is entitled.

Any payment we make in good faith will fully discharge us for that payment.

**Part payments.** Let us know as soon as you've recovered. If you recover during a month, we'll send you a pro-rata payment for the part of the month you were disabled.

**PART 5—OTHER BENEFITS**

*In PART 5, we discuss other benefits we provide.*

**Waiver of premiums.** We'll waive all premiums that come due after you've been totally and/or partially disabled for 90 days from the same sickness or injury. You won't have to pay premiums that come due while you remain disabled. We won't waive premiums beyond the maximum benefit period. We'll refund any premium paid for a period up to 90 days before you qualify for this benefit.

We'll waive premiums for this policy and any attached riders.

We'll waive premiums on the payment mode in effect when you become disabled.

**Exchange Privilege.** If, prior to attained age 60, you wish to apply to exchange this policy for one that provides benefits unrelated to business overhead expenses, you may make the exchange without producing additional evidence of good health or the nature of your occupation. The statements you made in your application for this policy will also apply to the new policy. You will have to prove that you are employed. You must not be totally or partially disabled.

The right to exchange your policy will be subject to the company's published limits of maximum monthly benefit based on your income, unearned income and other disability income coverage you may own. We may change these limits from time to time. If we do, you may elect to use the limits in effect when you purchased your original coverage or our new limits if higher. Your unearned income will be taken into consideration only if it exceeds the percentage published in our underwriting rules.

Subject to our published limits, the monthly benefit and elimination period under the new policy will be the same as the monthly benefit and elimination period on the Coverage Page of this policy. The new policy will be issued on the policy form the company then uses to provide total and partial disability benefits unrelated to business overhead expenses to new policyholders in the occupation described in the application for this policy. The maximum benefit period for the new policy will be two years. The cost of your new policy will be based on the rates new policyholders pay at the age when you apply for the exchange. The new policy may contain the same exclusions for diseases or physical conditions that this policy contained, if appropriate. Conversion will be made effective on the date of the application. Any unearned premium under this policy will be returned.

Upon exchange, we'll measure the time period stated in the "Contesting your policy" provision of any new policy from the issue date of that policy. If this policy can't be contested,

we can only use misstatements in the application for the new policy to contest that policy.

**Dividends.** Each year we determine how much can be paid as dividends on our policies. We call this "the divisible surplus". Then we figure how much of the divisible surplus can be paid as a dividend on all policies like yours.

We'll pay any dividends on the Anniversaries. We don't expect that there will be any before the second Anniversary.

We pay dividends in cash. But if you ask, we'll apply them toward premiums. Or, we'll accumulate them for you. We'll accumulate dividends at an interest rate of not less than 3% a year. We don't credit interest for any part of a year.

**Payment of premiums by accumulated dividends.** If you request it in the application, or in writing while this policy is premium paying, we'll automatically use accumulated dividends, if sufficient, to pay any premium in default. This also applies to the premium for any benefit rider attached to this policy.

**Reinstating the policy.** The policy will end if premiums are not paid when due or within the grace period.

If we don't require an application and evidence of your good health, you may reinstate the policy (restore coverage) by paying the back premiums. Pay us or one of our authorized agents. The reinstatement date will be the date you pay the back premiums.

If we do require an application, you'll have to pay back premiums and provide evidence of your good health. Then the reinstatement date will be the date that we approve your application. If you aren't notified of either approval or disapproval, the policy will be reinstated 45 days after the date of your application.

The reinstated policy will cover injuries that occur after the reinstatement date. It will cover sickness that first appears (makes itself known) more than 10 days after the reinstatement date.

After reinstatement, the terms of the policy and attached riders will be the same as before termination. Except for terms added in connection with reinstatement.

**Conditions for continuing the policy to age 75.** This policy ends on the Anniversary on or following your 65th birthday. But you may continue it each year until the Anniversary on or following your 75th birthday. This is provided you stay actively and gainfully employed full time, at least 30 hours a week.

You must tell us within 30 days before or after each Anniversary on or after your 65th birthday if you want to continue your policy. We may ask for proof that you're employed.

The maximum benefit period will be 12 months. We'll base the annual premium on your age and occupation then. Rates will be those we're using at that time.

If your active and gainful employment stops after we've continued your policy, coverage will end on the date you stop working. We'll refund any premiums paid for coverage after that date.

## PART 6—WHEN YOU'RE NOT COVERED

*There are certain disabilities we don't cover. And there are times when we may suspend coverage. We discuss this in PART 6.*

**Disabilities not covered.** We don't cover disability caused or contributed to by:

- war (declared or not)
- normal pregnancy, except as described in the definition of "sickness".
- normal childbirth, except as described in the definition of "sickness".

**Suspended coverage while in military.** This policy will be suspended if and when you enter active military service. This applies to the military service of any country or international authority. This doesn't apply to active duty for training that lasts 90 days or less.

We'll refund that part of any premium paid for the suspended period.

If you're released from active duty within 5 years from the date you entered active military service, you may restore this policy. Make written application and pay the required premium within 90 days of your release from active duty. No proof of insurability is needed. Premiums will be at the same rates as if the policy hadn't been suspended.

The restored policy will cover only injuries that occur after the restoration date. Or sickness that first appears (makes itself known) more than 10 days after the restoration date.

The terms of the restored policy and riders will be the same as before suspension.

**Pre-existing Conditions Limitations.** A disability or loss caused by a pre-existing condition not described on your application for this policy will be covered if the disability or loss commences 2 years after the effective date, as provided under the General Rule "Contesting Your Policy" in Part 7. A disability or loss caused by a pre-existing condition which you fully and accurately described in your application will not be contested unless the condition was excluded from coverage by name or specific description.

## PART 7—GENERAL RULES

*PART 7 contains general rules that apply.*

**The owner.** You (the insured) are the owner of this policy.

**The entire contract.** The entire contract consists of: The policy. The application. Any attached riders, endorsements and other papers.

**Changes.** Any change must be approved by an officer of our company. You must sign any change that restricts your policy. The change must be attached to the policy. Our agents cannot make changes or waive any provision.

**Assignments or transfers.** The benefits of this policy may be assigned. Any interest may be transferred. Our Home Office must receive written notice of the terms of the assignment or a copy of the assignment. If not, we won't take notice of the change. In any case, we won't be responsible for the validity of any assignment.

**Contesting your policy.** After this policy has been in force for a period of two years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application.

We won't deny a claim for disability which starts after 2 years from the date of issue because a disease or physical condition existed before coverage began; unless excluded from coverage by name or specific description.

We won't contest your policy or deny a claim for disability caused by a disease or physical condition which you fully and accurately described in your application for coverage; unless the condition was excluded from coverage by name or specific description.

**Legal actions.** No legal action may be brought to recover on this policy within 60 days after written proof of loss has been given as required by this policy. No such action may be brought after the expiration of this applicable statute of limitations from the time written proof of loss is required to be given.

**Misstating your age or sex.** If you misstate your age or sex in your application, we'll change the benefit amounts. The changed amounts will be what your premiums would have bought if you had given your correct age or sex.

But we'll only be required to make a refund if at your correct age or sex we wouldn't have issued the policy at all. Or if at your correct age or sex, coverage would have ended before we accepted the premium. The refund will only cover premiums you paid for coverage you won't receive. We'll deduct any amounts we've paid you.

**State laws.** Any provision that, on the effective date, conflicts with state laws where you reside, is changed to meet the minimum requirements of those laws.

**ENDORSEMENT**

**CONNECTICUT MUTUAL LIFE INSURANCE COMPANY**

**ConnMuMatic**

**PREMIUM PAYMENT SERVICE**

For the purpose of collecting premiums under this policy we will be authorized to withdraw funds from your account. If we accept this authorization premiums will be paid on a monthly basis.

Premiums will be computed at a percentage of the annual premium. The percentage is shown below. They will be payable on the first day of each policy year and every month thereafter.

If this authorization is no longer in effect, premiums will be payable monthly to the next quarterly increment. They will be payable quarterly thereafter. You may elect to pay premiums annually or semi-annually as provided in the Policy.

All terms of the Policy will apply to premiums on a monthly basis.

The word "Policy" as used in this form also means "Contract".

Issued by Connecticut Mutual Life Insurance Company, 140 Garden Street, Hartford, Connecticut.

**CONNECTICUT MUTUAL LIFE INSURANCE COMPANY**

*Oia Flanagan*

Secretary

Percentage of Premium	Applies To
8.54%	Policies below #3,288,000
8.62%	Policies above #3,288,000
8.70%	86 Series

ENDORSEMENT

CHANGE OF INSURER NAME AND ADDRESS  
NOTICE OF ANNUAL MEETING

CONNECTICUT MUTUAL LIFE INSURANCE COMPANY ("Connecticut Mutual") and MASSACHUSETTS MUTUAL LIFE INSURANCE COMPANY ("MassMutual") have merged. MassMutual is the surviving company. As a result, MassMutual has succeeded to all liabilities, duties and rights of Connecticut Mutual. All references in this policy/contract to Connecticut Mutual are hereby changed to MassMutual.

The MassMutual Home Office is:

Massachusetts Mutual Life Insurance Company  
Springfield, Massachusetts 01111-0001  
1-800-272-2216

The back page of this policy/contract is hereby changed to add the following Notice of Annual Meeting:

The Insured/Annuitant is hereby notified that by virtue of this policy/contract he or she is a member of Massachusetts Mutual Life Insurance Company and is entitled to vote either in person or by proxy at any and all meetings of said Company. The annual meetings are held at its Home Office, in Springfield, Massachusetts on the second Wednesday of April in each year at 2 o'clock p.m.

The Endorsement forms a part of, and should be attached to, this policy/contract.

MASSACHUSETTS MUTUAL LIFE INSURANCE COMPANY

*Pia Flanagan*

Secretary



Duplicate of Lost Policy

INSURED	POLICY NUMBER(S)
RICKY D GORDON	4963278

This policy is a duplicate of the original policy which has the same number and was prepared according to our current records. We issued this duplicate because we were furnished with evidence that the original policy was lost or destroyed.

If the original policy is ever found, it must be returned to us for cancellation.

This duplicate policy is issued under the terms of the Lost Policy Agreement filed with us at our Home Office.

10/31/2018

MASSACHUSETTS MUTUAL LIFE INSURANCE COMPANY

*Oja Flanagan*  
Secretary



JUN 7 REC'D

Application For Additional  
Disability Income Benefits

Connecticut Mutual Life Insurance Company, Hartford, Connecticut

IDENTIFICATION	1. A. The Name of the Insured is: <b>RICKY D. GOORIN</b>						
	B. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	C. You were born on: <b>1/10/19XX</b>		D. Your birth state is: <b>NY</b>	E. Your residence state is: <b>Florida</b>	F. Your business state is: <b>Florida</b>	
	G. Policy Number(s) affected by this application: <b>XXXXXX XXXXXX 4750574</b>					H. Your Social Security number is: <b>[REDACTED]</b>	

Complete Questions #2-10 for both an option under an adjustable benefit contract or an option under an additional benefits rider.

INSURABILITY	2. The Amount of the Additional Benefit is: <b>\$ 250.00</b>					6. Are you currently disabled? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	3. In what state are you employed? <b>Florida</b>					7. A. Will your employer continue salary or other payments if you are disabled? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	4. Existing Total Disability, Accident and Health Insurance					B. If yes, how much per month? <b>\$ 150.00</b>
	Source or Company	Monthly Income	Benefit Period	Year		C. How long? <b>months</b>
	Conn. Mutual	<b>DE</b>	<b>2500</b>	<b>1 yr/1 yr</b>	<b>1988</b>	8. A. Your annual earned income after business expenses but before taxes <b>\$ 150.00</b>
Total	<b>2500</b>	<b>2500</b>			B. All other annual income <b>\$ 0.00</b>	
5. Is the employer paying the premium under a qualified plan? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					9. The Amount of the Prepayment is: (must be prepaid) <b>\$ 13.53</b>	
					10. Have you smoked cigarettes within the last 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	

Complete Questions #11-15 only for an option under an additional benefits rider.

POLICY INFORMATION	11. <input checked="" type="checkbox"/> Regular Option				
	<input type="checkbox"/> Alternate Option for marriage, or after birth or adoption of a child:				
	I was married to _____		on _____	(Name of spouse) (Date)	
I am the parent of _____		as of _____	(Name of child) (Birth or adoption date)		
12. Premiums are payable: <input type="checkbox"/> A <input type="checkbox"/> SA <input type="checkbox"/> Q <input checked="" type="checkbox"/> MCS <input type="checkbox"/> Allot			14. Dividends: <input type="checkbox"/> Applied <input checked="" type="checkbox"/> Cash <input type="checkbox"/> Accumulate		
13. APD <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			15. Do you have dependent children? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		

COMMENTS	16. _____				

This Application is made in accordance with and subject to the provisions of the insurability agreement contained in the above policy. No agent may change the terms of this application or any coverage issued by the Company. And no agent may waive any of the Company's rights or requirements. If the date of issue of the coverage applied for is within two years of the Date of Issue of the Adjustable Benefit contract, or the additional benefits rider, the undersigned represent(s) that the statements and answers pertaining to the insurability of the proposed insured in the Application for that policy or rider were as of its date true and complete to the best knowledge and belief of the undersigned. The original Application shall form a part of this Application. This is agreed by the undersigned. Receipt of a Notice of Insurance Information Practices is hereby acknowledged.

Signed at ..... *Calumet, FLA* on ..... *6/8-1991*Witnessed by  
Soliciting Agent *By [Signature]*Signature of  
Proposed Insured *[Signature]*Signature of Owner of  
Original Policy if other  
than Proposed Insured *[Signature]*

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**BUSINESS OVERHEAD EXPENSE POLICY**

Noncancelable—Rates guaranteed

Guaranteed continuable to age 65

Conditionally continuable to age 75

Subject to premium change

Participating in dividends

Filing # 204983852 E-Filed 08/19/2024 10:09:17 AM

**Connecticut Mutual Life Insurance Company**  
Hartford, Connecticut • Since 1846

Insured

Policy Number

We at Connecticut Mutual Life believe you should read your policy. We've written it in plain English so you'll understand its terms. We will, subject to these terms, pay the benefits to you if you become disabled after the effective date.

**Benefits this policy provides**

- Business overhead expense payments during total disability
- Income during partial disability
- Premium waived during disability
- Dividends
- Conditional right to continue the policy to age 75

Your policy is issued in consideration of your application and premium payments. A copy of your application is attached and made a part of this policy.

We provide benefits for a loss arising from a sickness or disease that first appears (makes itself known) on or after the effective date and while this policy is in force. We also provide benefits for a loss resulting from an accidental bodily injury that happens on or after the effective date.

We won't cancel this policy. Nor will we increase the premiums. As long as you pay premiums on time, we'll continue coverage until the Anniversary on or following your 65th birthday.

**Policy Index**

PART 1 Definitions

PART 2 Disability benefits

PART 3 Premiums

PART 4 Claims

PART 5 Other benefits

PART 6 When you're not covered

PART 7 General rules

**Ten day right to examine.** If for any reason you decide not to keep this policy, send it to us within 10 days after receiving it. Send it to our Home Office or to the agent who sold it to you. We'll treat the policy as though it never had been issued. We'll refund any premium paid.

This policy is issued by Connecticut Mutual Life Insurance Company at our Home Office, 140 Garden Street, Hartford, Connecticut 06154 on the effective date.

*Pia Flemagem*

Secretary

*M. W. ...*

President

Registrar

Countersigned  
by \_\_\_\_\_, Licensed Resident Agent

**EXHIBIT E****BUSINESS OVERHEAD EXPENSE POLICY**

Noncancelable—Rates guaranteed

Guaranteed continuable to age 65

Conditionally continuable to age 75

Subject to premium change

Participating in dividends

COVERAGE PAGE

INSURED RICKY D GORDON 6012560 POLICY NUMBER  
DISABILITY INCOME POLICY

DATE OF ISSUE MAY 20, 1994  
DATE OF REISSUE OCT 29, 2018 AGE 39

EFFECTIVE DATE	COVERAGE	MONTHLY BENEFIT	WAITING PERIOD	MAXIMUM BENEFIT PERIOD	ANNUAL PREMIUM	PAYABLE TO YEAR
MAY 20 1994	MONTHLY OVERHEAD EXPENSE BENEFIT	\$2,500	90 DAYS	1 YEAR	\$139.50	2019
YOUR MAXIMUM MONTHLY BENEFIT IS	\$2,500		TOTAL ANNUAL PREMIUM		\$139.50	

IT IS ANTICIPATED THAT DIVIDENDS WILL BE PAYABLE AFTER 2 YEARS AND MAY BE USED AS  
DESCRIBED IN YOUR POLICY.

YOUR PREMIUM IS BASED ON NON-SMOKER RATES, DISCOUNTED BY 10% FROM THE SMOKER RATES.

**PART 1—DEFINITIONS**

*In PART 1, we define several terms used in this policy.*

**Effective date:** The date that the policy is "in effect." Coverage starts on that date. An Anniversary falls each year on the same month and day as the effective date.

**Elimination period:** The number of days immediately following the start of your disability. No benefits are provided during the elimination period. Your elimination period is shown on the Coverage Page.

**Maximum benefit period:** The maximum length of time we'll pay benefits.

**Sickness:** A sickness or disease that first appears (makes itself known) on or after the effective date. It includes disability from the transplant of a part of your body to the body of another and complications of pregnancy. After you have been totally disabled for 90 days, normal pregnancy and normal childbirth, for a pregnancy having its inception on or after the effective date, will be considered a sickness.

**Injury:** An accidental bodily injury that happens on or after the effective date.

**Occupation:** Your regular occupation at the start of disability.

**Doctor:** A licensed medical practitioner other than the insured.

**Income:** Gross earnings from any job or business. This doesn't include:

- Investment income.
- Rent.
- Royalties.
- Any amount which is deductible from gross income as a business expense for income tax purposes.

**Unearned Income:** All income which is not gross earnings from any job or business. This may include, but is not limited to:

- Investment income.
- Rent.
- Royalties.

**Proof of insurability:** Proof you give us, or that we might obtain, that you're an acceptable risk.

**Assignment:** Legal transfer of one's interest to another party.

**Pre-existing Condition:** A pre-existing condition is a physical condition or sickness which during the 5 year period prior to the effective date of this policy, caused the insured to have received medical advice or treatment.

**Overhead expenses:** Expenses you normally have in running your office or business. These expenses include, but are not limited to:

Rent	Electricity
Heat and water	Telephone
Interest payments on the business premises you own and use in running your business	Cost of leasing equipment
Employees' salaries (except as limited below)	Laundry
	Depreciation

Overhead expenses do not include:

Salaries, fees, drawing accounts or other compensation received by any family member, colleague or partner working for or with you.

Cost of goods for sale

Additions to inventory

Cost of tools, instruments or wares used in your profession or occupation.

Mortgage principal payments.

If overhead expenses are shared with one or more persons, we only cover your portion of the expenses.

**PART 2—DISABILITY BENEFITS**

*In PART 2, we discuss the different kinds of disability covered and the benefits we provide.*

**The kinds of disability covered**

**Total disability.** You're totally disabled if because of sickness or injury you can't do the main duties of your occupation. And you must be under a doctor's care.

You must be totally disabled for the full elimination period. We'll pay the first monthly benefit one month after the elimination period ends.

**Presumptive total disability.** If sickness or injury results in the total loss of sight, speech or hearing or the total loss of use of both hands, both feet, or one hand and one foot, it will be considered total disability while it continues. The requirement that you must be under a doctor's care will be waived.

**Partial disability.** You're partially disabled if because of sickness or injury:

- you can do some, but not all the duties of your occupation, or
- you can work at your occupation no more than 3/4 the hours you worked before becoming disabled

In either case, you must be under a doctor's care.

**Recurring disability.** This is a related disability that starts less than 6 months after a period of total or partial disability. We will treat the recurring disability as a continuation of the prior one. If the elimination period has already been satisfied, no new elimination period is required. If the elimination period has not been satisfied, periods of recurring disability may be accumulated to satisfy the elimination period.

*(Example: Bob's policy has a one-month elimination period for total disability. He has a stomach ulcer attack and is totally disabled for more than one month. Two months after returning to work, Bob has a second stomach ulcer attack and is totally disabled again for 2 months. The second attack is treated as a continuation of the first. So, Bob will start to receive total benefits without another elimination period.)*

**The benefits provided for disability**

**Total disability benefit—business overhead expense benefit.** Each monthly benefit we pay will either be equal to your share of the actual business overhead expenses, or be in the amount shown on the Coverage Page, whichever is less.

You will get benefits for as long as you are totally disabled, up to the maximum benefit period. If your actual expenses are less than the amount shown on the Coverage Page, we will extend benefits beyond the maximum benefit period. We will pay until the total benefit paid equals your monthly overhead expense benefit times your maximum benefit period. In no event, will we pay beyond the sixth month after the end of your maximum benefit period.

*(Example: Your monthly overhead expense benefit is \$1,000. Your maximum benefit period is 12 months. Your actual overhead expenses during 12 months came to \$10,000 and this is what we paid to the end of the maximum benefit period. We'll extend benefits until we pay another \$2,000 (\$12,000 - \$10,000). But we won't pay beyond the sixth month after the end of your maximum benefit period.)*

You won't get a larger benefit if you're disabled due to more than one cause.

**Partial disability benefit—business overhead expense benefit.** Benefits will start after the elimination period shown on the Coverage Page. We'll pay the first monthly benefit 1 month after the elimination period ends. We'll pay benefits up to the 12th month following the start of your disability.

The amount of your partial disability benefit will be 1/2 the total disability benefit.

We'll pay the partial disability benefit if you meet all the following conditions:

- You're totally and/or partially disabled for the elimination period shown on the Coverage Page.
- Your total disability benefits, if they were payable, have ended
- You're partially disabled but not totally disabled.

**PART 3—PREMIUMS**

*The annual premium is shown on the Coverage Page. In PART 3 we tell how, when and where to pay premiums.*

**Premium payments.** Premiums are due in advance. The first is due on the effective date. Premiums after the first are due on the same day of the month as the effective date. Premiums may be paid annually. Or they may be paid more frequently as we allow. They must be paid to our Home Office or to one of our authorized agents.

**Grace period.** Each premium after the first must be paid within 31 days after its due date. This 31 day period is called the "grace period." The policy will stay in effect during the grace period.

**Changing when you pay.** You may request a change in the frequency of your payments on any Anniversary. This request must be in writing. Any change is subject to our approval.

**Refund after death.** We'll refund any premium that was paid for coverage after the policy month in which you die. Our Home Office must first receive written notice of your death.

**PART 4—CLAIMS**

*There are certain things you must do when making a claim. In PART 4, we discuss these requirements. We also discuss payment of claims.*

**How to make a claim**

**Notice of disability.** Send a written notice of your disability to our Home Office or to one of our authorized agents. Send it within 20 days after the start of disability, or as soon as reasonably possible. There's no required form.

**Claim forms.** We'll then send you a claim form. If you don't receive one within 15 days after you sent notice, write us your own claim letter. Tell us what caused the disability. Describe your situation.

**Required proof.** Whether on our claim form or your claim

letter, send proof of your disability and any proof of monthly overhead expenses that may be required. Send it to our Home Office as soon as possible. Required proof must also be received within 90 days of each monthly benefit payment claimed. If it's not possible to send it within 90 days, send it as soon as reasonably possible. Your claim won't be reduced because of the delay. But we won't accept proof of loss later than 1 year after it was due. We'll make an exception if you weren't then competent to make the claim.

We may require from time to time that you be examined by doctors we choose. We'll pay the cost. We may also require from time to time, satisfactory proof of your expenses before and during disability.

**Payment of claims**

**When benefits are paid.** We'll pay benefits monthly.

**Whom we'll pay.** We'll pay benefits to you. If you're a minor or not competent to give a release, we may pay up to \$3,000 to any relative of yours who we believe is entitled.

If you die, we'll pay your estate all amounts due prior to your death. But we may pay up to \$3,000 to any relative of yours who we believe is entitled.

Any payment we make in good faith will fully discharge us for that payment.

**Part payments.** Let us know as soon as you've recovered. If you recover during a month, we'll send you a pro-rata payment for the part of the month you were disabled.

**PART 5—OTHER BENEFITS**

*In PART 5, we discuss other benefits we provide.*

**Waiver of premiums.** We'll waive all premiums that come due after you've been totally and/or partially disabled for 90 days from the same sickness or injury. You won't have to pay premiums that come due while you remain disabled. We won't waive premiums beyond the maximum benefit period. We'll refund any premium paid for a period up to 90 days before you qualify for this benefit.

We'll waive premiums for this policy and any attached riders.

We'll waive premiums on the payment mode in effect when you become disabled.

**Exchange Privilege.** If, prior to attained age 60, you wish to apply to exchange this policy for one that provides benefits unrelated to business overhead expenses, you may make the exchange without producing additional evidence of good health or the nature of your occupation. The statements you made in your application for this policy will also apply to the new policy. You will have to prove that you are employed. You must not be totally or partially disabled.

The right to exchange your policy will be subject to the company's published limits of maximum monthly benefit based on your income, unearned income and other disability income coverage you may own. We may change these limits from time to time. If we do, you may elect to use the limits in effect when you purchased your original coverage or our new limits if higher. Your unearned income will be taken into consideration only if it exceeds the percentage published in our underwriting rules.

Subject to our published limits, the monthly benefit and elimination period under the new policy will be the same as the monthly benefit and elimination period on the Coverage Page of this policy. The new policy will be issued on the policy form the company then uses to provide total and partial disability benefits unrelated to business overhead expenses to new policyholders in the occupation described in the application for this policy. The maximum benefit period for the new policy will be two years. The cost of your new policy will be based on the rates new policyholders pay at the age when you apply for the exchange. The new policy may contain the same exclusions for diseases or physical conditions that this policy contained, if appropriate. Conversion will be made effective on the date of the application. Any unearned premium under this policy will be returned.

Upon exchange, we'll measure the time period stated in the "Contesting your policy" provision of any new policy from the issue date of that policy. If this policy can't be contested,

we can only use misstatements in the application for the new policy to contest that policy.

**Dividends.** Each year we determine how much can be paid as dividends on our policies. We call this "the divisible surplus". Then we figure how much of the divisible surplus can be paid as a dividend on all policies like yours.

We'll pay any dividends on the Anniversaries. We don't expect that there will be any before the second Anniversary.

We pay dividends in cash. But if you ask, we'll apply them toward premiums. Or, we'll accumulate them for you. We'll accumulate dividends at an interest rate of not less than 3% a year. We don't credit interest for any part of a year.

**Payment of premiums by accumulated dividends.** If you request it in the application, or in writing while this policy is premium paying, we'll automatically use accumulated dividends, if sufficient, to pay any premium in default. This also applies to the premium for any benefit rider attached to this policy.

**Reinstating the policy.** The policy will end if premiums are not paid when due or within the grace period.

If we don't require an application and evidence of your good health, you may reinstate the policy (restore coverage) by paying the back premiums. Pay us or one of our authorized agents. The reinstatement date will be the date you pay the back premiums.

If we do require an application, you'll have to pay back premiums and provide evidence of your good health. Then the reinstatement date will be the date that we approve your application. If you aren't notified of either approval or disapproval, the policy will be reinstated 45 days after the date of your application.

The reinstated policy will cover injuries that occur after the reinstatement date. It will cover sickness that first appears (makes itself known) more than 10 days after the reinstatement date.

After reinstatement, the terms of the policy and attached riders will be the same as before termination. Except for terms added in connection with reinstatement.

**Conditions for continuing the policy to age 75.** This policy ends on the Anniversary or on following your 65th birthday. But you may continue it each year until the Anniversary on or following your 75th birthday. This is provided you stay actively and gainfully employed full time, at least 30 hours a week.

You must tell us within 30 days before or after each Anniversary on or after your 65th birthday if you want to continue your policy. We may ask for proof that you're employed.

The maximum benefit period will be 12 months. We'll base the annual premium on your age and occupation then. Rates will be those we're using at that time.

If your active and gainful employment stops after we've continued your policy, coverage will end on the date you stop working. We'll refund any premiums paid for coverage after that date.

#### **PART 6—WHEN YOU'RE NOT COVERED**

*There are certain disabilities we don't cover. And there are times when we may suspend coverage. We discuss this in PART 6.*

**Disabilities not covered.** We don't cover disability caused or contributed to by:

- war (declared or not)
- normal pregnancy, except as described in the definition of "sickness".
- normal childbirth, except as described in the definition of "sickness".

**Suspended coverage while in military.** This policy will be suspended if and when you enter active military service. This applies to the military service of any country or international authority. This doesn't apply to active duty for training that lasts 90 days or less.

We'll refund that part of any premium paid for the suspended period.

If you're released from active duty within 5 years from the date you entered active military service, you may restore this policy. Make written application and pay the required premium within 90 days of your release from active duty. No proof of insurability is needed. Premiums will be at the same rates as if the policy hadn't been suspended.

The restored policy will cover only injuries that occur after the restoration date. Or sickness that first appears (makes itself known) more than 10 days after the restoration date.

The terms of the restored policy and riders will be the same as before suspension.

**Pre-existing Conditions Limitations.** A disability or loss caused by a pre-existing condition not described on your application for this policy will be covered if the disability or loss commences 2 years after the effective date, as provided under the General Rule "Contesting Your Policy" in Part 7. A disability or loss caused by a pre-existing condition which you fully and accurately described in your application will not be contested unless the condition was excluded from coverage by name or specific description.

#### **PART 7—GENERAL RULES**

*PART 7 contains general rules that apply.*

**The owner.** You (the insured) are the owner of this policy.

**The entire contract.** The entire contract consists of: The policy. The application. Any attached riders, endorsements and other papers.

**Changes.** Any change must be approved by an officer of our company. You must sign any change that restricts your policy. The change must be attached to the policy. Our agents cannot make changes or waive any provision.

**Assignments or transfers.** The benefits of this policy may be assigned. Any interest may be transferred. Our Home Office must receive written notice of the terms of the assignment or a copy of the assignment. If not, we won't take notice of the change. In any case, we won't be responsible for the validity of any assignment.

**Contesting your policy.** After this policy has been in force for a period of two years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application.

We won't deny a claim for disability which starts after 2 years from the date of issue because a disease or physical condition existed before coverage began; unless excluded from coverage by name or specific description.

We won't contest your policy or deny a claim for disability caused by a disease or physical condition which you fully and accurately described in your application for coverage; unless the condition was excluded from coverage by name or specific description.

**Legal actions.** No legal action may be brought to recover on this policy within 60 days after written proof of loss has been given as required by this policy. No such action may be brought after the expiration of this applicable statute of limitations from the time written proof of loss is required to be given.

**Misstating your age or sex.** If you misstate your age or sex in your application, we'll change the benefit amounts. The changed amounts will be what your premiums would have bought if you had given your correct age or sex.

But we'll only be required to make a refund if at your correct age or sex we wouldn't have issued the policy at all. Or if at your correct age or sex, coverage would have ended before we accepted the premium. The refund will only cover premiums you paid for coverage you won't receive. We'll deduct any amounts we've paid you.

**State laws.** Any provision that, on the effective date, conflicts with state laws where you reside, is changed to meet the minimum requirements of those laws.

**ENDORSEMENT**

**CONNECTICUT MUTUAL LIFE INSURANCE COMPANY**

**ConnMuMatic**

**PREMIUM PAYMENT SERVICE**

For the purpose of collecting premiums under this policy we will be authorized to withdraw funds from your account. If we accept this authorization premiums will be paid on a monthly basis.

Premiums will be computed at a percentage of the annual premium. The percentage is shown below. They will be payable on the first day of each policy year and every month thereafter.

If this authorization is no longer in effect, premiums will be payable monthly to the next quarterly increment. They will be payable quarterly thereafter. You may elect to pay premiums annually or semi-annually as provided in the Policy.

All terms of the Policy will apply to premiums on a monthly basis.

The word "Policy" as used in this form also means "Contract".

Issued by Connecticut Mutual Life Insurance Company, 140 Garden Street, Hartford, Connecticut.

**CONNECTICUT MUTUAL LIFE INSURANCE COMPANY**

*Pia Flanagan*

Secretary

Percentage of Premium	Applies To
8.54%	Policies below #3,288,000
8.62%	Policies above #3,288,000
8.70%	86 Series

ENDORSEMENT

CHANGE OF INSURER NAME AND ADDRESS  
NOTICE OF ANNUAL MEETING

CONNECTICUT MUTUAL LIFE INSURANCE COMPANY ("Connecticut Mutual") and MASSACHUSETTS MUTUAL LIFE INSURANCE COMPANY ("MassMutual") have merged. MassMutual is the surviving company. As a result, MassMutual has succeeded to all liabilities, duties and rights of Connecticut Mutual. All references in this policy/contract to Connecticut Mutual are hereby changed to MassMutual.

The MassMutual Home Office is:

Massachusetts Mutual Life Insurance Company  
Springfield, Massachusetts 01111-0001  
1-800-272-2216

The back page of this policy/contract is hereby changed to add the following Notice of Annual Meeting:

The Insured/Annuitant is hereby notified that by virtue of this policy/contract he or she is a member of Massachusetts Mutual Life Insurance Company and is entitled to vote either in person or by proxy at any and all meetings of said Company. The annual meetings are held at its Home Office, in Springfield, Massachusetts on the second Wednesday of April in each year at 2 o'clock p.m.

The Endorsement forms a part of, and should be attached to, this policy/contract.

MASSACHUSETTS MUTUAL LIFE INSURANCE COMPANY

*Pia Flemagren*

Secretary



Duplicate of Lost Policy

INSURED	POLICY NUMBER(S)
RICKY D GORDON	6012560

This policy is a duplicate of the original policy which has the same number and was prepared according to our current records. We issued this duplicate because we were furnished with evidence that the original policy was lost or destroyed.

If the original policy is ever found, it must be returned to us for cancellation.

This duplicate policy is issued under the terms of the Lost Policy Agreement filed with us at our Home Office.

10/31/2018

MASSACHUSETTS MUTUAL LIFE INSURANCE COMPANY

*Pia Flanagan*  
Secretary



Agency No.  
008Application For Additional  
Disability Income Benefits

RECEIVED

APR 20 1994

NEW BUSINESS

Connecticut Mutual Life Insurance Company, Hartford, Connecticut

IDENTIFICATION	1. A. The Name of the Insured is: (first, middle, last)		RICHARD		GO ROON							
	B. Sex	<input checked="" type="checkbox"/> M <input type="checkbox"/> F	C. You were born on: (mo, day)		NY		D. Your birth state is:		E. Your residence state is:		F. Your business state is:	
G. Policy Number(s) affected by this application:		4,750,574										
H. Your Social Security number is: <i>(Signature)</i>												

Complete Questions #2—10 for both an option under an adjustable benefit contract or an option under an additional benefits rider.

INSURABILITY	2. The Amount of the Additional Benefit is: \$.....2,500.00.				6. Are you currently disabled? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	3. In what state are you employed? Florida				7. A. Will your employer continue salary or other payments if you are disabled? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	4. Existing Total Disability, Accident and Health Insurance				B. If yes, how much per month? \$.....			
	Source or Company	Monthly Income	Benefit Period	Year	Sickness	Accident	Sickness	Issued
	Conn. Mutual OE	\$000	\$000	365	365	88-91		
	Total	\$000	\$000					
5. Is the employer paying the premium under a qualified plan? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				C. How long? ..... months.				
				8. A. Your annual earned income after business expenses but before taxes \$.....230,000				
				B. All other annual income \$.....10,000				
				9. The Amount of the Prepayment is: (must be prepaid) \$.....12,000				
				10. Have you smoked cigarettes within the last 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				

Complete Questions #11—15 only for an option under an additional benefits rider.

POLICY INFORMATION	11. <input checked="" type="checkbox"/> Regular Option	
	<input type="checkbox"/> Alternate Option for marriage, or after birth or adoption of a child:	
	I was married to _____	on _____
(Name of spouse)		
I am the parent of _____		
as of _____		
(Name of child)		
(Birth or adoption date)		
12. Premiums are payable: <input type="checkbox"/> A <input type="checkbox"/> SA <input type="checkbox"/> Q <input checked="" type="checkbox"/> MCS <input type="checkbox"/> Allot		
13. APD <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
14. Dividends: <input type="checkbox"/> Applied <input checked="" type="checkbox"/> Cash <input type="checkbox"/> Accumulate		
15. Do you have dependent children? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		

COMMENTS	16.	

This Application is made in accordance with and subject to the provisions of the insurability agreement contained in the above policy. No agent may change the terms of this application or any coverage issued by the Company. And no agent may waive any of the Company's rights or requirements. If the date of issue of the coverage applied for is within two years of the Date of Issue of the Adjustable Benefit contract, or the additional benefits rider, the undersigned represent(s) that the statements and answers pertaining to the insurability of the proposed insured in the Application for that policy or rider were as of its date true and complete to the best knowledge and belief of the undersigned. The original Application shall form a part of this Application. This is agreed by the undersigned. Receipt of a Notice of Insurance Information Practices is hereby acknowledged.

Signed at ..... colorado springs, Co ..... on ..... 4/11/1994

Witnessed by  
Soliciting Agent ..... *R. L.*Signature of  
Proposed Insured ..... *JL*  
Signature of Owner of  
Original Policy if other  
than Proposed Insured ..... *JL*

## Application For Additional Life Insurance Benefits

Agency No. \_\_\_\_\_

Check one:  Connecticut Mutual Life Insurance Company  
 C.M. Life Insurance Company

IDENTIFICATION	1. A. The Name of the Insured is: _____ (first, middle, last)					
	B. Sex <input type="checkbox"/> M <input type="checkbox"/> F	C. You were born on: _____ (mo, day, yr)	D. Your birth state is: _____	E. Your residence state is: _____	F. Your business state is: _____	
OPTION TYPE	G. Policy Number(s) affected by this application:			H. Your Social Security number is: _____		
	I. Send premium notices to:  Street Address _____			City, State _____	Zip _____	
POLICY INFORMATION	2. <input type="checkbox"/> Regular Option <input type="checkbox"/> Survivor Insurability Option <input type="checkbox"/> Alternate Option for marriage, or after birth or adoption of a child:  I was married to _____ (Name of spouse) _____ on _____ (Date) _____			3. A. The Amount of Additional Benefit is: \$.....		
	B. The Amount of the Prepayment is: (must be prepaid) \$.....			5. A. Premiums are payable: <input type="checkbox"/> A <input type="checkbox"/> S <input type="checkbox"/> Q <input type="checkbox"/> MCS <input type="checkbox"/> Allot  B. APL <input type="checkbox"/> Yes <input type="checkbox"/> No  C. APD <input type="checkbox"/> Yes <input type="checkbox"/> No		
6. Are you currently disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No			7. Have you smoked cigarettes within the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No			
7. A. The Primary Beneficiary is: (First name, middle initial, surname and relationship)			B. The Contingent Beneficiary is: _____		C. The Owner is: (Full name and address)  Owner's Social Security No.: _____	
Comments: _____						

This Application is made in accordance with and subject to the provisions of the insurability rider contained in the above policy. No agent may change the terms of this Application or any policy issued by the Company. And no agent may waive any of the Company's rights or requirements. If the Date of Issue of the policy applied for is within two years of the Date of Issue of that rider; the undersigned represent(s) that the statements and answers pertaining to the insurability of the proposed insured contained in the Application for that rider were as of its date true and complete to the best knowledge and belief of the undersigned. The Application for the original policy shall form a part of this Application. This is agreed by the undersigned. Receipt of a Notice of Insurance Information Practices is hereby acknowledged.

Signed at \_\_\_\_\_ on \_\_\_\_\_, 19\_\_\_\_\_

Witnessed by \_\_\_\_\_  
Soliciting Agent \_\_\_\_\_

Signature of  
Proposed Insured \_\_\_\_\_

For Beneficiary-Insurance Option,  
Owner and Beneficiary of new Policy \_\_\_\_\_

**BUSINESS OVERHEAD EXPENSE POLICY**

Noncancelable—Rates guaranteed

Guaranteed continuable to age 65

Conditionally continuable to age 75

Subject to premium change

Participating in dividends

Filing # 204983852 E-Filed 08/19/2024 10:09:17 AM

**Connecticut Mutual**

140 Garden Street  
Hartford, CT 06154  
(203) 727-6500

April 18, 1988

Mr. Ricky D. Gordon  
3705 Bisc Boulevard  
Miami, FL 33137

Policy: 4,744,473

Dear Mr. Gordon:

Under the terms of your policies we state, in part, "You are disabled if because of sickness or injury you can't do the main duties of your occupation." Your policies define occupation as "Your regular occupation at the start of disability."

If you are practicing as a trial attorney on a full-time basis at the time of accident or sickness and such accident or sickness causes a disability, one of our considerations in determining our liability will be your inability to engage in your regular occupation as a trial attorney.

If your occupation changed between the time the application was completed and the date of a loss, the disability would be based on your inability to engage in your new occupation.

The actual determination of benefits must depend on the circumstances as they exist at the time the loss was claimed to have occurred, and the provisions of the policies in force.

I trust the above will be of assistance to you.

Sincerely,



E.J. Kupruck  
Assistant Vice President  
Claims

EJK:cbu  
cc: 008/13290

**EXHIBIT F**

IN THE CIRCUIT COURT OF THE 17TH JUDICIAL CIRCUIT,  
IN AND FOR BROWARD COUNTY, FLORIDA

CASE NO.:

RICKY D. GORDON,

Plaintiff,

vs.

MASSACIUISETTS MUTUAL LIFE  
INSURANCE COMPANY,

Defendant.

---

NOTICE OF SERVICE OF FIRST SET OF INTERROGATORIES TO  
DEFENDANT, MASSACHUSETTS MUTUAL LIFE INSURANCE COMPANY

The Defendant, MASSACHUSETTS MUTUAL LIFE INSURANCE COMPANY is hereby requested to and required to answer the attached Interrogatories propounded by the Plaintiff, RICKY D. GORDON, under oath, and further in accordance with the Florida Rules of Civil Procedure 1.340.

**FORM 1.997. CIVIL COVER SHEET**

The civil cover sheet and the information contained in it neither replace nor supplement the filing and service of pleadings or other documents as required by law. This form must be filed by the plaintiff or petitioner with the Clerk of Court for the purpose of reporting uniform data pursuant to section 25.075, Florida Statutes. (See instructions for completion.)

**I. CASE STYLE**

IN THE CIRCUIT/COUNTY COURT OF THE SEVENTEENTH JUDICIAL CIRCUIT,  
IN AND FOR BROWARD COUNTY, FLORIDA

Ricky D. Gordon

Plaintiff

Case # \_\_\_\_\_

Judge \_\_\_\_\_

vs.

Massachusetts Mutual Life Insurance Company

Defendant

**II. AMOUNT OF CLAIM**

Please indicate the estimated amount of the claim, rounded to the nearest dollar. The estimated amount of the claim is requested for data collection and clerical processing purposes only. The amount of the claim shall not be used for any other purpose.

- \$8,000 or less
- \$8,001 - \$30,000
- \$30,001- \$50,000
- \$50,001- \$75,000
- \$75,001 - \$100,000
- over \$100,000.00

**III. TYPE OF CASE** (If the case fits more than one type of case, select the most definitive category.) If the most descriptive label is a subcategory (is indented under a broader category), place an x on both the main category and subcategory lines.

**CIRCUIT CIVIL**

- Condominium
- Contracts and indebtedness
- Eminent domain
- Auto negligence
- Negligence—other
  - Business governance
  - Business torts
  - Environmental/Toxic tort
  - Third party indemnification
  - Construction defect
  - Mass tort
  - Negligent security
  - Nursing home negligence
  - Premises liability—commercial
  - Premises liability—residential
- Products liability
- Real Property/Mortgage foreclosure
  - Commercial foreclosure
  - Homestead residential foreclosure
  - Non-homestead residential foreclosure
  - Other real property actions
- Professional malpractice
  - Malpractice—business
  - Malpractice—medical
  - Malpractice—other professional
- Other
  - Antitrust/Trade regulation
  - Business transactions
  - Constitutional challenge—statute or ordinance
  - Constitutional challenge—proposed amendment
  - Corporate trusts
  - Discrimination—employment or other
  - Insurance claims
  - Intellectual property
  - Libel/Slander
  - Shareholder derivative action
  - Securities litigation
  - Trade secrets
  - Trust litigation

**COUNTY CIVIL**

- Small Claims up to \$8,000
- Civil
- Real property/Mortgage foreclosure

- Replevins
- Evictions
  - Residential Evictions
  - Non-residential Evictions
- Other civil (non-monetary)

### COMPLEX BUSINESS COURT

This action is appropriate for assignment to Complex Business Court as delineated and mandated by the Administrative Order. Yes  No

**IV. REMEDIES SOUGHT** (check all that apply):

- Monetary;
- Nonmonetary declaratory or injunctive relief;
- Punitive

**V. NUMBER OF CAUSES OF ACTION:** [ ]  
(Specify)

1

**VI. IS THIS CASE A CLASS ACTION LAWSUIT?**

- yes
- no

**VII. HAS NOTICE OF ANY KNOWN RELATED CASE BEEN FILED?**

- no
- yes If "yes," list all related cases by name, case number, and court.  
None

**VIII. IS JURY TRIAL DEMANDED IN COMPLAINT?**

- yes
- no

**IX. DOES THIS CASE INVOLVE ALLEGATIONS OF SEXUAL ABUSE?**

- yes
- no

I CERTIFY that the information I have provided in this cover sheet is accurate to the best of my knowledge and belief, and that I have read and will comply with the requirements of Florida Rule of Judicial Administration 2.425.

Signature: s/ Martin Jay Sperry  
Attorney or party

Fla. Bar # 144917  
(Bar # if attorney)

Martin Jay Sperry  
(type or print name)

08/16/2024  
Date

IN THE CIRCUIT COURT OF THE  
17TH JUDICIAL CIRCUIT, IN AND  
FOR BROWARD COUNTY, FLORIDA

CASE NO.:

RICKY D. GORDON,

Plaintiff,

vs.

MASSACHUSETTS MUTUAL LIFE  
INSURANCE COMPANY,

Defendant.

---

**REQUEST FOR PRODUCTION**

COMES NOW, the Plaintiff, RICKY D. GORDON, by and through his undersigned attorneys, and serves his Request for Production to Defendant, MASSACHUSETTS MUTUAL LIFE INSURANCE COMPANY (MASSMUTUAL), to produce for inspection and/or copying the following pursuant to the Florida Rules of Civil Procedure:

1. Any and all medical records, reports, memoranda, and/or letters to or from any medical professional which refer or relate to Ricky D. Gordon.
2. The complete underwriting file of MassMutual relating to the Plaintiff, Ricky D. Gordon, and his individual and Business Overhead Expense Policies with MassMutual.
3. Any and all claims manuals, training materials, or guidelines which relate to the Defendant's claims procedures regarding individual disability claims and Business Overhead Expense Policies.

4. Any and all investigative materials obtained in the ordinary course of your business, including witness statements, either written or recorded which relate in any way to the policies issued to the Plaintiff, Ricky D. Gordon, and to the benefits which he claims.
5. Copies and transcripts of any statements obtained by Defendant of the Plaintiff.
6. Any medical records or reports relied on by the Defendant in the denial of Plaintiff's claim for total and residual disability benefits for both individual and Business Overhead Expense Policies.
7. Copies of all reports prepared by physicians or psychologists who examined and evaluated Plaintiff on behalf of Defendant.

**CERTIFICATE OF SERVICE**

I HEREBY CERTIFY that a true and correct copy of the foregoing was served with the Complaint in this action.

Dated on this \_\_\_\_\_ day of \_\_\_\_\_, 2024.

By /s/ Martin J. Sperry  
MARTIN J. SPERRY  
Florida Bar No. 144917  
MARTIN J. SPERRY, P.A.  
3860 W. Commercial Boulevard  
Ft. Lauderdale, FL 33309  
(954) 727-0997 Telephone  
(954) 727-0998 Facsimile  
[msperry@mpsperrylawfirm.com](mailto:msperry@mpsperrylawfirm.com)  
[ssklaw@aol.com](mailto:ssklaw@aol.com)  
[lcolman@mpsperrylawfirm.com](mailto:lcolman@mpsperrylawfirm.com)